

APPENDIX C

CARE AREA ASSESSMENT (CAA) RESOURCES

Chapter 4 of this manual provides information on specific care areas triggered and the CAA process. This appendix contains both specific and general resources that nursing homes may choose to use to further assess care areas triggered from the MDS 3.0 resident assessment instrument. The resources include the care area specific tools beginning in this section and the general resource list at the end of this appendix.

It is important to note that the resources provided in this appendix are provided solely as a courtesy for use by nursing homes, should they choose to, in completing the RAI CAA process. **It is also important to reiterate that CMS does not mandate, nor does it endorse, the use of any particular resource(s), including those provided in this appendix.** However, nursing homes should ensure that the resource(s) used are current, evidence-based or expert-endorsed research and clinical practice guidelines/resources.

DISCLAIMER: The list of resources in this appendix is neither prescriptive nor all-inclusive. References to non-U.S. Department of Health and Human Services (HHS) sources or sites on the Internet are provided as a service and do not constitute or imply endorsement of these organizations or their programs by CMS or HHS. CMS is not responsible for the content of pages found at these sites. URL addresses were current as of the date of this publication.

CARE AREA SPECIFIC RESOURCES

The specific resources or tools contained on the next several pages are provided by care area. The general instructions for using them include:

Step 1: After completing the MDS, review all MDS items and responses to determine if any care areas have been triggered.

Step 2: For any triggered care area(s), conduct a thorough assessment of the resident using the care area-specific resources.

Step 3: Check the box in the left column if the item is present for this resident. *Some of this information will be on the MDS - some will not.*

Step 4: In the right column the facility can provide a summary of supporting documentation regarding the basis or reason for checking a particular item or items. This could include the location and date of that information, symptoms, possible causal and contributing factor(s) for item(s) checked, etc.

Step 5: Obtain and consider input from resident and/or family/resident's representative regarding the care area.

Step 6: Analyze the findings in the context of their relationship to the care area and standards of practice. This should include a review of indicators and supporting documentation, including symptoms and causal and contributing factors, related to this care area. Draw conclusions about the causal/contributing factors and effect(s) on the resident, and document these conclusions in the Analysis of Findings section.

Step 7: Decide whether referral to other disciplines is warranted and document this decision.

Step 8: In the Care Plan Considerations section, document whether a care plan for the triggered care area will be developed and the reason(s) why or why not.

Step 9: Information in the *Supporting Documentation* column can be used to populate the *Location and Date of CAA Documentation* column in Section V, Item V0200A (CAA Results) – for e.g. “See Delirium CAA 4/30/11, H&P dated 4/18/11.”

NOTE: An optional Signature/Date line has been added to each checklist. This was added if the facility wants to document the staff member who completed the checklist and date completed.

DISCLAIMER: The checklists of care area specific resources in this appendix are not mandated, prescriptive, or all-inclusive and are provided as a service to facilities. They do not constitute or imply endorsement by CMS or HHS.

TABLE OF CONTENTS

| | |
|----------------------------------------------------------------------------------------|------|
| 1. Delirium | C-5 |
| 2. Cognitive Loss/Dementia..... | C-10 |
| 3. Visual Function | C-14 |
| 4. Communication..... | C-17 |
| 5. Activities of Daily Living (ADLs) – Functional Status/Rehabilitation Potential..... | C-21 |
| 6. Urinary Incontinence and Indwelling Catheter..... | C-25 |
| 7. Psychosocial Well-Being | C-29 |
| 8. Mood State | C-33 |
| 9. Behavioral Symptoms | C-36 |
| 10. Activities | C-41 |
| 11. Fall(s) | C-45 |
| 12. Nutritional Status | C-50 |
| 13. Feeding Tube(s) | C-55 |
| 14. Dehydration/Fluid Maintenance | C-58 |
| 15. Dental Care | C-62 |
| 16. Pressure Ulcer(s)..... | C-65 |
| 17. Psychotropic Medication Use | C-69 |
| 18. Physical Restraints | C-74 |
| 19. Pain | C-78 |
| 20. Return to Community Referral | C-82 |
| Care Area General Resources | C-84 |

1. DELIRIUM**Review of Indicators of Delirium**

| ✓ | Changes in vital signs compared to baseline | Supporting Documentation (Basis/reason for checking the item, including the location, date, and source (if applicable) of that information) |
|--------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <input type="checkbox"/> | Temperatures 2.4°F higher than baseline or a temperature of 100.4°F (38°C) on admission prior to establishment of baseline. (J1550A) | |
| <input type="checkbox"/> | Pulse rate less than 60 or greater than 100 beats per minute | |
| <input type="checkbox"/> | Respiratory rate over 25 breaths per minute or less than 16 per minute (J1100) | |
| <input type="checkbox"/> | Hypotension or a significant decrease in blood pressure: (I0800) | |
| <input type="checkbox"/> | <ul style="list-style-type: none"> Systolic blood pressure of less than 90 mm Hg, OR | |
| <input type="checkbox"/> | <ul style="list-style-type: none"> Decline of 20 mm Hg or greater in systolic blood pressure from person's usual baseline, OR | |
| <input type="checkbox"/> | <ul style="list-style-type: none"> Decline of 10 mm Hg or greater in diastolic blood pressure from person's usual baseline, OR | |
| <input type="checkbox"/> | Hypertension - a systolic blood pressure above 160 mm Hg, OR a diastolic blood pressure above 95 mm Hg (I0700) | |

| ✓ | Abnormal laboratory values (from clinical record) | |
|--------------------------|--------------------------------------------------------------------------------|--|
| <input type="checkbox"/> | <ul style="list-style-type: none"> Electrolytes, such as sodium | |
| <input type="checkbox"/> | <ul style="list-style-type: none"> Kidney function | |
| <input type="checkbox"/> | <ul style="list-style-type: none"> Liver function | |
| <input type="checkbox"/> | <ul style="list-style-type: none"> Blood sugar | |
| <input type="checkbox"/> | <ul style="list-style-type: none"> Thyroid function | |
| <input type="checkbox"/> | <ul style="list-style-type: none"> Arterial blood gases | |
| <input type="checkbox"/> | <ul style="list-style-type: none"> Other | |

| ✓ | Pain | |
|--------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|
| <input type="checkbox"/> | <ul style="list-style-type: none"> Pain CAA triggered (J0100, J0200) [review findings for relationship to delirium (C1300)] | |
| <input type="checkbox"/> | <ul style="list-style-type: none"> Pain frequency, intensity, and characteristics (time of onset, duration, quality) (J0400, J0600, J0800, J0850 and clinical record) indicate possible relationship to delirium (C1300) | |
| <input type="checkbox"/> | <ul style="list-style-type: none"> Adverse effect of pain on function (J0500A, J0500B) may be related to delirium (C1300) | |

| ✓ | Diseases and conditions (diagnosis/signs/symptoms) | Supporting Documentation (Basis/reason for checking the item, including the location, date, and source (if applicable) of that information) |
|--------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <input type="checkbox"/> | <ul style="list-style-type: none"> • Circulatory/Heart <ul style="list-style-type: none"> — Anemia (I0200) — Cardiac dysrhythmias (I0300) — Angina, Myocardial Infarction (MI) (I0400) — Atherosclerotic Heart Disease (ASHD) (I0400) — Congestive Heart Failure (CHF) pulmonary edema (I0600) — Cerebrovascular Accident (CVA) (I4500) — Transient Ischemic Attack (TIA) (I4500) | |
| <input type="checkbox"/> | <ul style="list-style-type: none"> • Respiratory <ul style="list-style-type: none"> — Asthma (I6200) — Emphysema/Chronic Obstructive Pulmonary Disease (COPD) (I6200) — Shortness of breath (J1100) — Ventilator or respirator (O0100F) — Respiratory Failure (I6300) | |
| <input type="checkbox"/> | <ul style="list-style-type: none"> • Infectious <ul style="list-style-type: none"> — Infections (I1700-I2500) — Wound infection other than on foot or lower extremity (M) (I2500) — Isolation or quarantine for active infectious disease (O0100M) | |
| <input type="checkbox"/> | <ul style="list-style-type: none"> • Metabolic <ul style="list-style-type: none"> — Diabetes (I2900) — Thyroid disease (I3400) — Hyponatremia (I3100) | |
| <input type="checkbox"/> | • Gastrointestinal bleed (clinical record) | |
| <input type="checkbox"/> | • Renal disease (I1500), Dialysis (O0100J) | |
| <input type="checkbox"/> | • Hospice care (O0100K) | |
| <input type="checkbox"/> | • Cancer (I0100) | |
| <input type="checkbox"/> | • Dehydration (J1550C, clinical record) | |

| ✓ | Signs of Infection (from observation, clinical record) | |
|--------------------------|---------------------------------------------------------------|--|
| <input type="checkbox"/> | • Fever (J1550A) | |
| <input type="checkbox"/> | • Cloudy or foul smelling urine | |
| <input type="checkbox"/> | • Congested lungs or cough | |
| <input type="checkbox"/> | • Dyspnea (J1100) | |
| <input type="checkbox"/> | • Diarrhea | |
| <input type="checkbox"/> | • Abdominal pain | |
| <input type="checkbox"/> | • Purulent wound drainage | |
| <input type="checkbox"/> | • Erythema (redness) around an incision | |

| ✓ | Indicators of Dehydration | Supporting Documentation (Basis/reason for checking the item, including the location, date, and source (if applicable) of that information) |
|--------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------|
| <input type="checkbox"/> | <ul style="list-style-type: none"> Dehydration CAA triggered, indicating signs or symptoms of dehydration are present (J1550C) | |
| <input type="checkbox"/> | <ul style="list-style-type: none"> Recent decrease in urine volume or more concentrated urine than usual (I and O) (clinical record) | |
| <input type="checkbox"/> | <ul style="list-style-type: none"> Recent decrease in eating habits – skipping meals or leaving food uneaten, weight loss (K0300) | |
| <input type="checkbox"/> | <ul style="list-style-type: none"> Nausea, vomiting (J1550B), diarrhea, or blood loss | |
| <input type="checkbox"/> | <ul style="list-style-type: none"> Receiving intravenous drugs (O0100H) | |
| <input type="checkbox"/> | <ul style="list-style-type: none"> Receiving diuretics or drugs that may cause electrolyte imbalance (medication administration record)(N0410G) | |

| ✓ | Functional Status | |
|--------------------------|-------------------------------------------------------------------------------------------------------------------------------------|--|
| <input type="checkbox"/> | <ul style="list-style-type: none"> Recent decline in ADL status (Section G0110) (may be related to delirium) (C1300) | |
| <input type="checkbox"/> | <ul style="list-style-type: none"> Increased risk for falls (J1700) (may be related to delirium) (See Falls CAA) | |

| ✓ | Medications (that may contribute to delirium) | |
|--------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|
| <input type="checkbox"/> | <ul style="list-style-type: none"> New medication(s) or dosage increase(s) | |
| <input type="checkbox"/> | <ul style="list-style-type: none"> Drugs with anticholinergic properties (for example, some antipsychotics (N0410A), antidepressants (N0410C), antiparkinsonian drugs, antihistamines) | |
| <input type="checkbox"/> | <ul style="list-style-type: none"> Opioids (narcotic pain drug) | |
| <input type="checkbox"/> | <ul style="list-style-type: none"> Benzodiazepines, especially long-acting agents (N0410B) | |
| <input type="checkbox"/> | <ul style="list-style-type: none"> Analgesics, cardiac and GI medications, anti-inflammatory drugs | |
| <input type="checkbox"/> | <ul style="list-style-type: none"> Recent abrupt discontinuation, omission, or decrease in dose of a short or long acting benzodiazepines (N0410B) | |
| <input type="checkbox"/> | <ul style="list-style-type: none"> Drug interactions (pharmacist review may be required) | |
| <input type="checkbox"/> | <ul style="list-style-type: none"> Resident taking more than one drug from a particular class of drugs | |
| <input type="checkbox"/> | <ul style="list-style-type: none"> Possible drug toxicity, especially if the person is dehydrated (J1550C) or has renal insufficiency (I1500). Check serum drug levels | |

| ✓ | Associated or progressive signs and symptoms | Supporting Documentation (Basis/reason for checking the item, including the location, date, and source (if applicable) of that information) |
|--------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------|
| <input type="checkbox"/> | <ul style="list-style-type: none"> Sleep disturbances (for example, up and awake at night/asleep during the day) (D0100C, D0500C) | |
| <input type="checkbox"/> | <ul style="list-style-type: none"> Agitation and inappropriate movements (for example, unsafe climbing out of bed or chair, pulling out tubes) (E0500) | |
| <input type="checkbox"/> | <ul style="list-style-type: none"> Hypoactivity (for example, low or lack of motor activity, lethargy or sluggish responses) (D0200D, D0500D) | |
| <input type="checkbox"/> | <ul style="list-style-type: none"> Perceptual disturbances such as hallucinations (E0100A) and delusions (E0100B) | |

| ✓ | Other Considerations | |
|--------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|
| <input type="checkbox"/> | Psychosocial <ul style="list-style-type: none"> Recent change in mood; sad or anxious (for example, crying, social withdrawal) (D0200, D0500) Recent change in social situation (for example, isolation, recent loss of family member or friend) Use of restraints (P0100, clinical record) | |
| <input type="checkbox"/> | Physical or environmental factors <ul style="list-style-type: none"> Hearing or vision impairment (B0200, B1000) - may have an impact on ability to process information (directions, reminders, environmental cues) Lack of frequent reorientation, reassurance, reminders to help make sense of things Recent change in environment (for example, a room or unit change, new admission, or return from hospital) (A1700) Interference with resident's ability to get enough sleep (for example, light, noise, frequent disruptions) Noisy or chaotic environment (for example, calling out, loud music, constant commotion, frequent caregiver changes) | |

| |
|-------------------------------------------------------------------------------------------------------------------------------------------|
| Input from resident and/or family/representative regarding the care area. (Questions/Comments/Concerns/Preferences/Suggestions) |
| |

| Analysis of Findings | | Care Plan Considerations |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------|----------------------------------------------------------|
| Review indicators and supporting documentation, and draw conclusions. Document: <ul style="list-style-type: none"> • Description of the problem; • Causes and contributing factors; and • Risk factors related to the care area. | Care Plan Y/N | Document reason(s) care plan will/will not be developed. |
| | | |

Referral(s) to another discipline(s) is warranted (to whom and why): _____

Information regarding the CAA transferred to the CAA Summary (Section V of the MDS):

☐ Yes ☐ No

Signature/Title: _____ Date: _____

2. COGNITIVE LOSS/DEMENTIA**Review of Indicators of Cognitive Loss/Dementia**

| | | |
|--------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------|
| ✓ | Reversible causes of cognitive loss | Supporting Documentation (Basis/reason for checking the item, including the location, date, and source (if applicable) of that information) |
| <input type="checkbox"/> | <ul style="list-style-type: none"> Delirium (C1300) CAA triggered (Immediate follow-up required. Perform the Delirium CAA to determine possible causes, contributing factors, etc., and go directly to care planning for those issues. Then continue below.) | |
| ✓ | Neurological factors | |
| <input type="checkbox"/> | <ul style="list-style-type: none"> Intellectual disability/Developmental Disability (A1550) | |
| <input type="checkbox"/> | <ul style="list-style-type: none"> Alzheimer's Disease or other dementias (I4200, I4800) | |
| <input type="checkbox"/> | <ul style="list-style-type: none"> Parkinson's Disease (I5300) | |
| <input type="checkbox"/> | <ul style="list-style-type: none"> Traumatic brain injury (I5500) | |
| <input type="checkbox"/> | <ul style="list-style-type: none"> Brain tumor (clinical record) | |
| <input type="checkbox"/> | <ul style="list-style-type: none"> Normal pressure hydrocephalus | |
| <input type="checkbox"/> | <ul style="list-style-type: none"> Other (clinical record, I8000) | |
| ✓ | Observable characteristics and extent of this resident's cognitive loss | |
| <input type="checkbox"/> | <ul style="list-style-type: none"> Analyze component of Brief Interview for Mental Status (BIMS) (C0200-C0500) (V0100D) | |
| <input type="checkbox"/> | <ul style="list-style-type: none"> If unable to complete BIMS, analyze components of Staff Assessment for Mental Status (C0700, C0800, C0900, C1000) | |
| <input type="checkbox"/> | <ul style="list-style-type: none"> Identify components of Delirium assessment (C1300) that are present and not new onset or worsening | |
| <input type="checkbox"/> | <ul style="list-style-type: none"> Confusion, disorientation, forgetfulness (observation, clinical record) (C0200, C0300, C0400, C0500, C0700, C0800, C0900, C1300, C1600) | |
| <input type="checkbox"/> | <ul style="list-style-type: none"> Decreased ability to make self understood (B0700) or to understand others (B0800) | |
| <input type="checkbox"/> | <ul style="list-style-type: none"> Impulsivity (observation, clinical record) | |
| <input type="checkbox"/> | <ul style="list-style-type: none"> Other (observation, clinical record) | |

| ✓ | Mood and behavior | Supporting Documentation (Basis/reason for checking the item, including the location, date, and source (if applicable) of that information) |
|--------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------|
| <input type="checkbox"/> | <ul style="list-style-type: none"> • Mood State (D0100) CAA triggered. Analysis of Findings indicates possible impact on cognition – important to consider when drawing conclusions about cognitive loss | |
| <input type="checkbox"/> | <ul style="list-style-type: none"> • Behavioral Symptoms (E0200) CAA triggered: Analysis of Findings points to cause(s), contributing factors, etc. – important to consider when drawing conclusions about cognitive loss | |

| ✓ | Medical problems that can impact cognition | |
|--------------------------|------------------------------------------------------------------------------------------------------------------------------------------|--|
| <input type="checkbox"/> | <ul style="list-style-type: none"> • Constipation (H0600), fecal impaction, diarrhea | |
| <input type="checkbox"/> | <ul style="list-style-type: none"> • Diabetes (I2900) | |
| <input type="checkbox"/> | <ul style="list-style-type: none"> • Thyroid Disorder (I3400) | |
| <input type="checkbox"/> | <ul style="list-style-type: none"> • Congestive heart failure (I0600)/other cardiac diseases (I0300, I0400) | |
| <input type="checkbox"/> | <ul style="list-style-type: none"> • Respiratory problems (I6200, I6300, I2000, I2200, I8000)/decreased oxygen saturation | |
| <input type="checkbox"/> | <ul style="list-style-type: none"> • Cancer (I0100) | |
| <input type="checkbox"/> | <ul style="list-style-type: none"> • Liver disease (I1100, I2400, I8000, clinical record) | |
| <input type="checkbox"/> | <ul style="list-style-type: none"> • Renal failure (I1500) | |
| <input type="checkbox"/> | <ul style="list-style-type: none"> • Psychiatric or mood disorder (I5700-I6100) | |
| <input type="checkbox"/> | <ul style="list-style-type: none"> • Electrolyte imbalance (clinical record) | |
| <input type="checkbox"/> | <ul style="list-style-type: none"> • Poor nutrition (I5600) or hydration status (J1550C) (clinical record) | |
| <input type="checkbox"/> | <ul style="list-style-type: none"> • End of life (Hospice O0100K and clinical record) | |
| <input type="checkbox"/> | <ul style="list-style-type: none"> • Alcoholism (I8000) | |
| <input type="checkbox"/> | <ul style="list-style-type: none"> • Failure to thrive (I8000) | |

| ✓ | Pain and its relationship to cognitive loss and behavior | |
|--------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|
| <input type="checkbox"/> | <ul style="list-style-type: none"> • Indications that pain is present (J0100, J0300, J0400, J0500, J0600, J0700, J0800, J0850) | |
| <input type="checkbox"/> | <ul style="list-style-type: none"> • Pain CAA triggered. Determine relationship between pain and cognitive status via observation and assessment. | |

| ✓ | Functional status and its relationship to cognitive loss | Supporting Documentation (Basis/reason for checking the item, including the location, date, and source (if applicable) of that information) |
|--------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------|
| <input type="checkbox"/> | <ul style="list-style-type: none"> Activities of Daily Living (ADL) status (Section G) <ul style="list-style-type: none"> ADL Care Area triggered (G0110). Analysis of Findings provides important information about relationship of ADL decline to cognitive loss (C0500, C0700, C0800, C0900, C1000, V0100D) Resident has potential for more independence with cueing, restorative nursing program, and/or task segmentation or other programs (G0600, O0100 – O0500) | |
| <input type="checkbox"/> | <ul style="list-style-type: none"> Decline in continence (H0300, H0400, clinical record) | |
| <input type="checkbox"/> | <ul style="list-style-type: none"> Impaired daily decision-making (C1000, clinical record) | |
| <input type="checkbox"/> | <ul style="list-style-type: none"> Participates better in small group programs (F0800P, observation, clinical record) | |
| <input type="checkbox"/> | <ul style="list-style-type: none"> Staff and/or resident believe resident is capable of doing more (G0900) | |

| ✓ | Other Considerations | |
|--------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|
| <input type="checkbox"/> | <ul style="list-style-type: none"> Cognitive decline occurred slowly over time (V0100D) | |
| <input type="checkbox"/> | <ul style="list-style-type: none"> Unexplainable behavior may be attempt at communication about pain, toileting needs, uncomfortable position, etc. | |
| <input type="checkbox"/> | <ul style="list-style-type: none"> Use of physical restraints (P0100) | |
| <input type="checkbox"/> | <ul style="list-style-type: none"> Hearing or vision impairment (B0200, B0300, B1000, B1200) - may have an impact on ability to process information (directions, reminders, environmental cues) | |
| <input type="checkbox"/> | <ul style="list-style-type: none"> Lack of frequent reorientation, reassurance, reminders to help make sense of things (C0900, C1300) | |
| <input type="checkbox"/> | <ul style="list-style-type: none"> Interference with the resident's ability to get enough sleep (noise, light, etc.) (D0200C, D0500C) | |
| <input type="checkbox"/> | <ul style="list-style-type: none"> Noisy or chaotic environment (for example, calling out, loud music, constant commotion, frequent caregiver changes) | |

| |
|-------------------------------------------------------------------------------------------------------------------------------------------|
| Input from resident and/or family/representative regarding the care area. (Questions/Comments/Concerns/Preferences/Suggestions) |
| |

| Analysis of Findings | | Care Plan Considerations |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------|-----------------------------------------------------------|
| Review indicators and supporting documentation, and draw conclusions. Document: <ul style="list-style-type: none"> • Description of the problem; • Causes and contributing factors; and • Risk factors related to the care area. | Care Plan Y/N | Document reason(s) care plan will/ will not be developed. |
| | | |

Referral(s) to another discipline(s) is warranted (to whom and why): _____

Information regarding the CAA transferred to the CAA Summary (Section V of the MDS):

☐ Yes ☐ No

Signature/Title: _____ Date: _____

3. VISUAL FUNCTION**Review of Indicators of Visual Function**

| ✓ | Diseases and conditions of the eye (diagnosis OR signs/symptoms present) | Supporting Documentation (Basis/reason for checking the item, including the location, date, and source (if applicable) of that information) |
|--------------------------|---------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------|
| <input type="checkbox"/> | • Cataracts, Glaucoma, or Macular Degeneration (I6500) | |
| <input type="checkbox"/> | • Diabetic retinopathy (I2900) | |
| <input type="checkbox"/> | • Blindness (B1000 = 3 or 4) | |
| <input type="checkbox"/> | • Decreased visual acuity (B1000, B1200 = 1) | |
| <input type="checkbox"/> | • Visual field deficit (B1200 = 1) | |
| <input type="checkbox"/> | • Eye pain (J0800) | |
| <input type="checkbox"/> | • Blurred vision | |
| <input type="checkbox"/> | • Double vision | |
| <input type="checkbox"/> | • Sudden loss of vision | |
| <input type="checkbox"/> | • Itching/burning eye | |
| <input type="checkbox"/> | • Indications of eye infection (I8000) | |

| ✓ | Diseases and conditions that can cause visual disturbances | |
|--------------------------|-----------------------------------------------------------------------------------------|--|
| <input type="checkbox"/> | • Cerebrovascular accident or transient ischemic attack (I4500) | |
| <input type="checkbox"/> | • Alzheimer's Disease and other dementias (I4200, I4800) | |
| <input type="checkbox"/> | • Myasthenia gravis (I8000, clinical record) | |
| <input type="checkbox"/> | • Multiple sclerosis (I5200) | |
| <input type="checkbox"/> | • Cerebral palsy (I4400) | |
| <input type="checkbox"/> | • Mood ((I5800, I5900, I5950, I6000, I6100, D0300 or D0600) or anxiety disorder (I5700) | |
| <input type="checkbox"/> | • Traumatic brain injury (I5500) | |
| <input type="checkbox"/> | • Other (I8000) | |

| ✓ | Functional limitations related to vision problems (from clinical record, resident and staff interviews, direct observation) | Supporting Documentation (Basis/reason for checking the item, including the location, date, and source (if applicable) of that information) |
|--------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------|
| <input type="checkbox"/> | <ul style="list-style-type: none"> Peripheral vision or other visual problem that impedes ability to eat, walk, or interact with others (B1000 = 3, 4) | |
| <input type="checkbox"/> | <ul style="list-style-type: none"> Ability to recognize staff limited by vision problem (B1000 = 3, 4) | |
| <input type="checkbox"/> | <ul style="list-style-type: none"> Difficulty negotiating the environment due to vision problem (B1000 = 3, 4) | |
| <input type="checkbox"/> | <ul style="list-style-type: none"> Balance problems (G0300) exacerbated by vision problem (B1000, B1200) | |
| <input type="checkbox"/> | <ul style="list-style-type: none"> Participation in self-care limited by vision problem (B1000) | |
| <input type="checkbox"/> | <ul style="list-style-type: none"> Difficulty seeing television, reading material of interest, or participating in activities of interest because of vision problem (B1000 = 2, 3, 4) | |
| <input type="checkbox"/> | <ul style="list-style-type: none"> Increased risk for falls due to vision problems or due to bifocals or trifocals (B1200 = 1) | |

| ✓ | Environment | |
|--------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|
| <input type="checkbox"/> | <ul style="list-style-type: none"> Is resident's environment adapted to his or her unique needs, such as availability of large print books, high wattage reading lamp, night light, etc.? | |
| <input type="checkbox"/> | <ul style="list-style-type: none"> Are there aspects the facility's environment that should be altered to enhance vision, such as low-glare floors, low glare tables and surfaces, large print signs marking rooms, etc.? | |

| ✓ | Medications that can impair vision (consultant pharmacist review of medication regimen can be very helpful) | |
|--------------------------|-----------------------------------------------------------------------------------------------------------------------|--|
| <input type="checkbox"/> | <ul style="list-style-type: none"> Narcotics | |
| <input type="checkbox"/> | <ul style="list-style-type: none"> Antipsychotics (N0410A) | |
| <input type="checkbox"/> | <ul style="list-style-type: none"> Antidepressants (N0410C) | |
| <input type="checkbox"/> | <ul style="list-style-type: none"> Anticholinergics | |
| <input type="checkbox"/> | <ul style="list-style-type: none"> Hypnotics (N0410D) | |
| <input type="checkbox"/> | <ul style="list-style-type: none"> Other | |

| ✓ | Use of visual appliances (B1200) | |
|--------------------------|--------------------------------------------------------------------|--|
| <input type="checkbox"/> | <ul style="list-style-type: none"> Reading glasses | |
| <input type="checkbox"/> | <ul style="list-style-type: none"> Distance glasses | |
| <input type="checkbox"/> | <ul style="list-style-type: none"> Contact lenses | |
| <input type="checkbox"/> | <ul style="list-style-type: none"> Magnifying glass | |

| |
|-------------------------------------------------------------------------------------------------------------------------------------------|
| Input from resident and/or family/representative regarding the care area. (Questions/Comments/Concerns/Preferences/Suggestions) |
| |

| Analysis of Findings | | Care Plan Considerations |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------|-----------------------------------------------------------|
| Review indicators and supporting documentation, and draw conclusions. Document: <ul style="list-style-type: none"> • Description of the problem; • Causes and contributing factors; and • Risk factors related to the care area. | Care Plan Y/N | Document reason(s) care plan will/ will not be developed. |
| | | |

Referral(s) to another discipline(s) is warranted (to whom and why): _____

Information regarding the CAA transferred to the CAA Summary (Section V of the MDS):

☐ Yes ☐ No

Signature/Title: _____ Date: _____

4. COMMUNICATION**Review of Indicators of Communication**

| ✓ | Diseases and conditions that may be related to communication problems | Supporting Documentation (Basis/reason for checking the item, including the location, date, and source (if applicable) of that information) |
|--------------------------|------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------|
| <input type="checkbox"/> | • Alzheimer's Disease or other dementias (I4200, I4800, I8000) | |
| <input type="checkbox"/> | • Aphasia (I4300) following a cerebrovascular accident (I4500) | |
| <input type="checkbox"/> | • Parkinson's disease (I5300) | |
| <input type="checkbox"/> | • Mental health problems (I5700 – I6100) | |
| <input type="checkbox"/> | • Conditions that can cause voice production deficits, such as | |
| <input type="checkbox"/> | — Asthma (I6200) | |
| <input type="checkbox"/> | — Emphysema/COPD (I6200) | |
| <input type="checkbox"/> | — Cancer (I0100) | |
| <input type="checkbox"/> | — Poor-fitting dentures (L0200) | |
| <input type="checkbox"/> | • Transitory conditions, such as | |
| <input type="checkbox"/> | — Delirium (C1300, I8000, clinical record) | |
| <input type="checkbox"/> | — Infection (I1700 – I2500) | |
| <input type="checkbox"/> | — Acute illness (I8000, clinical record) | |
| <input type="checkbox"/> | • Other (I8000, clinical record) | |

| ✓ | Medications (consultant pharmacist review of medication regimen can be very helpful) | |
|--------------------------|---------------------------------------------------------------------------------------------|--|
| <input type="checkbox"/> | • Narcotic analgesics (medication administration record) | |
| <input type="checkbox"/> | • Antipsychotics (N0410A) | |
| <input type="checkbox"/> | • Antianxiety (N0410B) | |
| <input type="checkbox"/> | • Antidepressants (N0410C) | |
| <input type="checkbox"/> | • Parkinson's medications (medication administration record) | |
| <input type="checkbox"/> | • Hypnotics (N0410D) | |
| <input type="checkbox"/> | • Gentamycin (N0410F) (medication administration record) | |
| <input type="checkbox"/> | • Tobramycin (N0410F) (medication administration record) | |
| <input type="checkbox"/> | • Aspirin (medication administration record) | |
| <input type="checkbox"/> | • Other (clinical record) | |

| ✓ | Characteristics of the communication impairment (from clinical record) | Supporting Documentation (Basis/reason for checking the item, including the location, date, and source (if applicable) of that information) |
|--------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------|
| <input type="checkbox"/> | • Expressive communication (B0700) | |
| <input type="checkbox"/> | — Speaks different language (A1100) | |
| <input type="checkbox"/> | — Disruption in ability to speak (B0600, clinical record) | |
| <input type="checkbox"/> | — Problem with voice production, low volume (B0600, clinical record) | |
| <input type="checkbox"/> | — Word-finding problems (clinical record) | |
| <input type="checkbox"/> | — Difficulty putting sentence together (B0700, C1300B, clinical record) | |
| <input type="checkbox"/> | — Problem describing objects and events (B0700, clinical record) | |
| <input type="checkbox"/> | — Pronouncing words incorrectly (B0600, clinical record) | |
| <input type="checkbox"/> | — Stuttering (B0700, clinical record) | |
| <input type="checkbox"/> | — Hoarse or distorted voice (clinical record) | |
| <input type="checkbox"/> | • Receptive communication (B0800) | |
| <input type="checkbox"/> | — Does not understand English (A1100) | |
| <input type="checkbox"/> | — Hearing impairment (B0200, B0300 = 1, B0800) | |
| <input type="checkbox"/> | — Speech discrimination problems (clinical record) | |
| <input type="checkbox"/> | — Decreased vocabulary comprehension (clinical record) (A1100A-B) | |
| <input type="checkbox"/> | — Difficulty reading and interpreting facial expressions (clinical record, direct observation) | |
| <input type="checkbox"/> | • Communication is more successful with some individuals than with others. Identify and build on the successful approaches (clinical record, interviews, observation) | |
| <input type="checkbox"/> | • Limited opportunities for communication due to social isolation or need for communication devices (clinical record, interviews) | |
| <input type="checkbox"/> | • Communication problem may be mistaken as cognitive impairment | |

| ✓ | Confounding problems that may need to be resolved before communication will improve | Supporting Documentation (Basis/reason for checking the item, including the location, date, and source (if applicable) of that information) |
|--------------------------|-----------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------|
| <input type="checkbox"/> | • Decline in cognitive status (clinical record) and BIMS decline (C0500, V0100D) | |
| <input type="checkbox"/> | • Mood problem, increase in PHQ-9 score (D0300, D0600, V0100E) | |
| <input type="checkbox"/> | • Increased dependence in Activities of Daily Living (ADLs) (clinical record, changes in G0110, G0120) | |
| <input type="checkbox"/> | • Deterioration in respiratory status (clinical record) | |
| <input type="checkbox"/> | • Oral motor function problems, such as swallowing, clarity of voice production (B0600, K0100, clinical record) | |

| ✓ | Use of communication devices (from clinical record, observation) | |
|--------------------------|-------------------------------------------------------------------------|--|
| <input type="checkbox"/> | • Hearing aid (B0300) | |
| <input type="checkbox"/> | • Written communication | |
| <input type="checkbox"/> | • Sign language | |
| <input type="checkbox"/> | • Braille | |
| <input type="checkbox"/> | • Signs, gestures, sounds | |
| <input type="checkbox"/> | • Communication board | |
| <input type="checkbox"/> | • Electronic assistive devices | |
| <input type="checkbox"/> | • Other | |

| |
|-------------------------------------------------------------------------------------------------------------------------------------------|
| Input from resident and/or family/representative regarding the care area. (Questions/Comments/Concerns/Preferences/Suggestions) |
| |

| Analysis of Findings | | Care Plan Considerations |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------|-----------------------------------------------------------|
| Review indicators and supporting documentation, and draw conclusions. Document: <ul style="list-style-type: none"> • Description of the problem; • Causes and contributing factors; and • Risk factors related to the care area. | Care Plan Y/N | Document reason(s) care plan will/ will not be developed. |
| | | |

Referral(s) to another discipline(s) is warranted (to whom and why): _____

Information regarding the CAA transferred to the CAA Summary (Section V of the MDS):

☐ Yes ☐ No

Signature/Title: _____ Date: _____

5. ACTIVITIES OF DAILY LIVING (ADLs) – FUNCTIONAL STATUS/REHABILITATION POTENTIAL

Review of Indicators of ADLs - Functional Status/Rehabilitation Potential

| ✓ | Possible underlying problems that may affect function. Some may be reversible. | Supporting Documentation (Basis/reason for checking the item, including the location, date, and source (if applicable) of that information) |
|--------------------------|----------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------|
| <input type="checkbox"/> | • Delirium (C1300) (clinical record and Delirium CAA) | |
| <input type="checkbox"/> | • Acute episode or flare-up of chronic condition (I8000, clinical record) | |
| <input type="checkbox"/> | • Changing cognitive status (C0100) (see Cognitive Loss CAA) | |
| <input type="checkbox"/> | • Mood decline (D0100)(clinical record and Mood State CAA) | |
| <input type="checkbox"/> | • Daily behavioral symptoms/decline in behavior(E0200) (see Behavioral Symptoms CAA) | |
| <input type="checkbox"/> | • Use of physical restraints(P0100) (See Physical Restraints CAA) | |
| <input type="checkbox"/> | • Pneumonia (I2000) | |
| <input type="checkbox"/> | • Fall(J1700) (from record and Falls CAA) | |
| <input type="checkbox"/> | • Hip fracture (I3900) | |
| <input type="checkbox"/> | • Recent hospitalization (clinical record) (A1700, A1800= 3, 4) | |
| <input type="checkbox"/> | • Fluctuating ADLs (G0110A-J, G0120, G0300A-E, G0900) (observation, clinical record) | |
| <input type="checkbox"/> | • Nutritional problems (K0510A1, K0510A2) (clinical record and Nutrition CAA) | |
| <input type="checkbox"/> | • Pain(J0700) (See Pain CAA) | |
| <input type="checkbox"/> | • Dizziness | |
| <input type="checkbox"/> | • Communication problems (B0200, B0700, B0800) (clinical record and Communication CAA) | |
| <input type="checkbox"/> | • Vision problems(B1000) (observation, interview, clinical record, and Vision CAA) | |

| ✓ | Abnormal laboratory values (from clinical record) | |
|--------------------------|----------------------------------------------------------|--|
| <input type="checkbox"/> | • Electrolytes | |
| <input type="checkbox"/> | • Complete blood count | |
| <input type="checkbox"/> | • Blood sugar | |
| <input type="checkbox"/> | • Thyroid function | |
| <input type="checkbox"/> | • Arterial blood gases | |
| <input type="checkbox"/> | • Other | |

| | | |
|-------------------------------------|------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------|
| <input checked="" type="checkbox"/> | Medications that can contribute to functional decline | Supporting Documentation (Basis/reason for checking the item, including the location, date, and source (if applicable) of that information) |
| <input type="checkbox"/> | • Psychoactive medications (N0410A-D) | |
| <input type="checkbox"/> | • Other medications – ask consultant pharmacist to review medication regimen to identify these medications | |

| | | |
|-------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|
| <input checked="" type="checkbox"/> | Limiting factors resulting in need for assistance with any of the ADLs (observation, interview, clinical record) | |
| <input type="checkbox"/> | • Mental errors such as sequencing problems, incomplete performance, or anxiety limitations | |
| <input type="checkbox"/> | • Physical limitations such as weakness (G0110A–J.1 = 2,3, 4) (G0110 A-J.2 = 2, 3), limited range of motion (G0400A = 1, 2, G0400B = 1, 2), poor coordination, poor balance (G0300A-E =2), visual impairment (B1000 = 1-4), or pain (J0300 = 1, J0700 =1) | |
| <input type="checkbox"/> | • Facility conditions such as policies, rules, or physical layout | |

| | | |
|-------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|
| <input checked="" type="checkbox"/> | Problems resident is at risk for because of functional decline (from observation, assessment, clinical record) | |
| <input type="checkbox"/> | • Falls (J1700) | |
| <input type="checkbox"/> | • Weight loss (K0300) | |
| <input type="checkbox"/> | • Unidentified pain (J0700) | |
| <input type="checkbox"/> | • Social isolation | |
| <input type="checkbox"/> | • Restraint use (P0100) | |
| <input type="checkbox"/> | • Depression(D0100) | |
| <input type="checkbox"/> | • Complications of immobility, such as — Pressure ulcers (M0210) — Muscular atrophy — Contractures (G0400 A, B = 1, 2) — Incontinence (H0300, H0400) — Urinary (I2300) and respiratory infections | |

| |
|-------------------------------------------------------------------------------------------------------------------------------------------|
| Input from resident and/or family/representative regarding the care area. (Questions/Comments/Concerns/Preferences/Suggestions) |
| |

| Analysis of Findings | | Care Plan Considerations |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------|-----------------------------------------------------------|
| Review indicators and supporting documentation, and draw conclusions. Document: <ul style="list-style-type: none"> • Description of the problem; • Causes and contributing factors; and • Risk factors related to the care area. | Care Plan Y/N | Document reason(s) care plan will/ will not be developed. |
| | | |

Referral(s) to another discipline(s) is warranted (to whom and why): _____

Information regarding the CAA transferred to the CAA Summary (Section V of the MDS):

☐ Yes ☐ No

Signature/Title: _____ Date: _____

Where rehabilitation goals are envisioned, use of the *ADL Supplement* will help care planners to focus on those areas that might be improved, allowing them to choose from among a number of basic tasks in designated areas. Part 1 of the supplement can assist in the evaluation of all residents that trigger this care area. Part 2 of the supplement can be helpful for residents with rehabilitation potential (ADL Triggers A), to help plan a treatment program.

ADL SUPPLEMENT
(Attaining maximum possible Independence)

| PART 1: ADL Problem Evaluation INSTRUCTIONS: For those triggered - In areas physical help provided, indicate reason(s) for this help. | | | | | | |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------|-------------------------------------------|------------------------------------------------------------|-----------------------------------------------------------------------------|-------------------------------------------------------|---------------------------------------------------------------|
| | DRESSING | BATHING | TOILETING | LOCOMOTION | TRANSFER | EATING |
| Mental Errors: Sequencing problems, incomplete performance, anxiety limitations, etc. Physical Limitations: Weakness, limited range of motion, poor coordination, visual impairment, pain, etc. Facility Conditions: Policies, rules, physical layout, etc. | | | | | | |
| PART 2: Possible ADL Goals INSTRUCTIONS: For those considered for rehabilitation or decline prevention treatment - <div style="text-align: right;">If wheelchair, check: <input type="checkbox"/></div> | | | | | | |
| Indicate specific type of ADL activity that might require: 1. Maintenance to prevent decline. 2. Treatment to achieve highest practical self- sufficiency (selecting ADL abilities that are just above those the resident can now perform or participate in). | Locates/ selects/ obtains clothes | Goes to tub/ shower | Goes to toilet (include commode/ urinal at night) | Walks in room/ nearby <input type="checkbox"/> | Positions self in preparation | Opens/ pours/ unwraps/ cuts etc. |
| | Grasps/puts on upper lower body | Turns on water/ adjusts temperature | Removes/ opens clothes in preparation | Walks on unit <input type="checkbox"/> | Approaches chair/bed | Grasps utensils and cups |
| | Manages snaps, zippers, etc. | Lathers body (except back) | Transfers/ positions self | Walks throughout building (uses elevator) <input type="checkbox"/> | Prepares chair/bed (locks pad, moves covers) | Scoops/ spears food (uses fingers when necessary) |
| | Puts on in correct order | Rinses body | Eliminates into toilet | Walks outdoors <input type="checkbox"/> | Transfers (stands/sits/ lifts/turns) | Chews, drinks, swallows |
| | Grasps, removes each item | Dries with towel | Tears/uses paper to clean self | Walks on uneven surfaces <input type="checkbox"/> | Repositions/ arranges self | Repeats until food consumed |
| | Replaces clothes properly | Other | Flushes | Other <input type="checkbox"/> | Other | Uses napkins, cleans self |
| | Other | | Adjusts clothes, washes hands | | | Other |

6. URINARY INCONTINENCE AND INDWELLING CATHETER**Review of Indicators of Urinary Incontinence and Indwelling Catheter**

| ✓ | Modifiable factors contributing to transitory urinary incontinence | Supporting Documentation (Basis/reason for checking the item, including the location, date, and source (if applicable) of that information) |
|--------------------------|--------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------|
| <input type="checkbox"/> | • Delirium (C1300) (See Delirium CAA) | |
| <input type="checkbox"/> | • Urinary Tract Infection (I2300) | |
| <input type="checkbox"/> | • Atrophic vaginitis in postmenopausal women (I8000) | |
| <input type="checkbox"/> | • Medications (see below) | |
| <input type="checkbox"/> | • Psychological or psychiatric problems (I5700-I6100) | |
| <input type="checkbox"/> | • Constipation/impaction (H0600, clinical record) | |
| <input type="checkbox"/> | • Caffeine use | |
| <input type="checkbox"/> | • Excessive fluid intake | |
| <input type="checkbox"/> | • Pain (J0300) | |
| <input type="checkbox"/> | • Environmental factors | |
| <input type="checkbox"/> | — Restricted mobility (G0110.1.A-F. = 2, 3,4)(G0110.2.A-F.=2, 3) (See ADL CAA) | |
| <input type="checkbox"/> | — Lack of access to a toilet | |
| <input type="checkbox"/> | — Other environmental barriers (such as pads or briefs) | |
| <input type="checkbox"/> | — Restraints (P0100) | |

| ✓ | Other factors that contribute to incontinence or catheter use | |
|--------------------------|------------------------------------------------------------------------------|--|
| <input type="checkbox"/> | • Excessive or inadequate urine output | |
| <input type="checkbox"/> | • Urinary urgency AND need for assistance in toileting (G0110.1.I = 2, 3, 4) | |
| <input type="checkbox"/> | • Bladder cancer (I0100) or stones (I8000) | |
| <input type="checkbox"/> | • Spinal cord or brain lesions (I8000) | |
| <input type="checkbox"/> | • Tabes dorsalis (I8000) | |
| <input type="checkbox"/> | • Neurogenic bladder (I1550) | |

| ✓ | Laboratory tests | |
|--------------------------|--------------------------|--|
| <input type="checkbox"/> | • High serum calcium | |
| <input type="checkbox"/> | • High blood glucose | |
| <input type="checkbox"/> | • Low B12 | |
| <input type="checkbox"/> | • High BUN or creatinine | |

| | | Supporting Documentation (Basis/reason for checking the item, including the location, date, and source (if applicable) of that information) |
|--------------------------|-----------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------|
| ✓ | Diseases and conditions | |
| <input type="checkbox"/> | • Benign prostatic hypertrophy (I1400) | |
| <input type="checkbox"/> | • Congestive Heart Failure (CHF), pulmonary edema (I0600) | |
| <input type="checkbox"/> | • Cerebrovascular Accident (CVA) (I4500) | |
| <input type="checkbox"/> | • Transient Ischemic Attack (TIA) (I4500) | |
| <input type="checkbox"/> | • Diabetes (I2900) | |
| <input type="checkbox"/> | • Depression (I5800) | |
| <input type="checkbox"/> | • Parkinson's disease (I5300) | |
| <input type="checkbox"/> | • Prostate cancer (I0100) | |

| | | |
|--------------------------|----------------------------------------------------------------------------------------------------------------------------------|--|
| ✓ | Type of incontinence | |
| <input type="checkbox"/> | • Stress (occurs with coughing, sneezing, laughing, lifting heavy objects, etc.) | |
| <input type="checkbox"/> | • Urge (overactive or spastic bladder) | |
| <input type="checkbox"/> | • Mixed (stress incontinence with urgency) | |
| <input type="checkbox"/> | • Overflow (due to blocked urethra or weak bladder muscles) | |
| <input type="checkbox"/> | • Transient (temporary/occasional related to a potentially improvable/reversible cause) | |
| <input type="checkbox"/> | • Functional (can't get to toilet in time due to physical disability, external obstacles, or problems thinking or communicating) | |

| | | |
|--------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|
| ✓ | Medications (from medication administration record and preadmission records if new admission; review by consultant pharmacist) | |
| <input type="checkbox"/> | • Diuretics(N0410G)– can cause urge incontinence | |
| <input type="checkbox"/> | • Sedative hypnotics (N0410B, N0410D) | |
| <input type="checkbox"/> | • Anticholinergics – can lead to overflow incontinence — Parkinson's medications (except Sinemet and Deprenyl) — Disopyramide — Antispasmodics — Antihistamines — Antipsychotics (N0410A) — Antidepressants (N0410C) — Narcotics | |
| <input type="checkbox"/> | • Drugs that stimulate or block sympathetic nervous system | |
| <input type="checkbox"/> | • Calcium channel blockers | |

| | | |
|--------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------|
| ✓ | Use of indwelling catheter (H0100 is checked): (Presence of situation in which catheter use <i>may</i> be appropriate intervention after consideration of risks/benefits and after efforts to avoid catheter use have been unsuccessful) | Supporting Documentation (Basis/reason for checking the item, including the location, date, and source (if applicable) of that information) |
| <input type="checkbox"/> | • Coma (B0100) | |
| <input type="checkbox"/> | • Terminal illness (O0100K) | |
| <input type="checkbox"/> | • Stage 3 or 4 pressure ulcer in area affected by incontinence | |
| <input type="checkbox"/> | • Need for exact measurement of urine output | |
| <input type="checkbox"/> | • History of inability to void after catheter removal | |

| |
|-------------------------------------------------------------------------------------------------------------------------------------------|
| Input from resident and/or family/representative regarding the care area. (Questions/Comments/Concerns/Preferences/Suggestions) |
| |

| Analysis of Findings | | Care Plan Considerations |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------|-----------------------------------------------------------|
| Review indicators and supporting documentation, and draw conclusions. Document: <ul style="list-style-type: none"> • Description of the problem; • Causes and contributing factors; and • Risk factors related to the care area. | Care Plan Y/N | Document reason(s) care plan will/ will not be developed. |
| | | |

Referral(s) to another discipline(s) is warranted (to whom and why): _____

Information regarding the CAA transferred to the CAA Summary (Section V of the MDS):

☐ Yes ☐ No

Signature/Title: _____ Date: _____

7. PSYCHOSOCIAL WELL-BEING**Review of Indicators of Psychosocial Well-Being**

| ✓ | Modifiable factors for relationship problems (from resident, family, staff interviews and clinical record) | Supporting Documentation (Basis/reason for checking the item, including the location, date, and source (if applicable) of that information) |
|--------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------|
| <input type="checkbox"/> | <ul style="list-style-type: none"> Resident says or indicates he or she feels lonely —Recent decline in social involvement and associated loneliness can be sign of acute health complications and depression | |
| <input type="checkbox"/> | <ul style="list-style-type: none"> Resident indicates he or she feels distressed because of decline in social activities | |
| <input type="checkbox"/> | <ul style="list-style-type: none"> Over the past few years, resident has experienced absence of daily exchanges with relatives and friends | |
| <input type="checkbox"/> | <ul style="list-style-type: none"> Resident is uneasy dealing with others | |
| <input type="checkbox"/> | <ul style="list-style-type: none"> Resident has conflicts with family, friends, roommate, other residents, or staff | |
| <input type="checkbox"/> | <ul style="list-style-type: none"> Resident appears preoccupied with the past and unwilling to respond to needs of the present | |
| <input type="checkbox"/> | <ul style="list-style-type: none"> Resident seems unable or reluctant to begin to establish a social role in the facility; may be grieving lost status or roles | |
| <input type="checkbox"/> | <ul style="list-style-type: none"> Recent change in family situation or social network, such as death of a close family member or friend | |
| ✓ | Customary lifestyle (from resident, family, staff interviews and clinical record) (Section F) | |
| <input type="checkbox"/> | <ul style="list-style-type: none"> Was lifestyle more satisfactory to the resident prior to admission to the nursing home? | |
| <input type="checkbox"/> | <ul style="list-style-type: none"> Are current psychosocial/relationship problems consistent with resident's long-standing lifestyle or is this relatively new for the resident? | |
| <input type="checkbox"/> | <ul style="list-style-type: none"> Has facility care plan to date been as consistent as possible with resident's prior lifestyle, preferences, and routines (F0400, F0600, F0800)? | |

| | | Supporting Documentation (Basis/reason for checking the item, including the location, date, and source (if applicable) of that information) |
|--------------------------|--------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| ✓ | Diseases and conditions that may impede ability to interact with others | |
| <input type="checkbox"/> | • Delirium (C1300, C1600 = 1, Delirium CAA) | |
| <input type="checkbox"/> | • Intellectual disability /developmental disability (A1550) | |
| <input type="checkbox"/> | • Alzheimer's disease (I4200) | |
| <input type="checkbox"/> | • Aphasia (I4300) | |
| <input type="checkbox"/> | • Other dementia (I4800) | |
| <input type="checkbox"/> | • Depression (I5800) | |

| | | |
|--------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|
| ✓ | Health status factors that may inhibit social involvement | |
| <input type="checkbox"/> | • Decline in activities of daily living (G0110) | |
| <input type="checkbox"/> | • Health problem, such as falls (J1700, J1800), pain (J0300, J0800), fatigue, etc. | |
| <input type="checkbox"/> | • Mood (D0200A1, D0300, D0500A1, D0600) or behavior (E0200) problem that impacts interpersonal relationships or that arises because of social isolation (See Mood State and Behavioral Symptoms CAAs) | |
| <input type="checkbox"/> | • Change in communication (B0700, B0800), vision (B1000), hearing (B0200), cognition (C0100, C0600) | |
| <input type="checkbox"/> | • Medications with side effects that interfere with social interactions, such as incontinence, diarrhea, delirium, or sleepiness | |

| | | |
|--------------------------|-----------------------------------------------------------------------------------------------|--|
| ✓ | Environmental factors that may inhibit social involvement | |
| <input type="checkbox"/> | • Use of physical restraints (P0100) | |
| <input type="checkbox"/> | • Change in residence leading to loss of autonomy and reduced self-esteem (A1700) | |
| <input type="checkbox"/> | • Change in room assignment or dining location or table mates | |
| <input type="checkbox"/> | • Living situation limits informal social interaction, such as isolation precautions (O0100M) | |

| ✓ | Strengths to build upon (from resident, family, staff interviews and clinical record) | Supporting Documentation (Basis/reason for checking the item, including the location, date, and source (if applicable) of that information) |
|--------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------|
| <input type="checkbox"/> | <ul style="list-style-type: none"> Activities in which resident appears especially at ease interacting with others | |
| <input type="checkbox"/> | <ul style="list-style-type: none"> Certain situations appeal to resident more than others, such as small groups or 1:1 interactions rather than large groups | |
| <input type="checkbox"/> | <ul style="list-style-type: none"> Certain individuals who seem to bring out a more positive, optimistic side of the resident | |
| <input type="checkbox"/> | <ul style="list-style-type: none"> Positive traits that distinguished the resident as an individual prior to his or her illness | |
| <input type="checkbox"/> | <ul style="list-style-type: none"> What gave the resident a sense of satisfaction earlier in his or her life? | |

| |
|-------------------------------------------------------------------------------------------------------------------------------------------|
| Input from resident and/or family/representative regarding the care area. (Questions/Comments/Concerns/Preferences/Suggestions) |
| |

| Analysis of Findings | | Care Plan Considerations |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------|-----------------------------------------------------------|
| Review indicators and supporting documentation, and draw conclusions. Document: <ul style="list-style-type: none"> • Description of the problem; • Causes and contributing factors; and • Risk factors related to the care area. | Care Plan Y/N | Document reason(s) care plan will/ will not be developed. |
| | | |

Referral(s) to another discipline(s) is warranted (to whom and why): _____

Information regarding the CAA transferred to the CAA Summary (Section V of the MDS):

☐ Yes ☐ No

Signature/Title: _____ Date: _____

8. MOOD STATE**Review of Indicators of Mood**

| ✓ | Psychosocial changes | Supporting Documentation (Basis/reason for checking the item, including the location, date, and source (if applicable) of that information) |
|--------------------------|------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------|
| <input type="checkbox"/> | • Personal loss | |
| <input type="checkbox"/> | • Recent move into or within the nursing home (A1700) | |
| <input type="checkbox"/> | • Recent change in relationships, such as illness or loss of a relative or friend | |
| <input type="checkbox"/> | • Recent change in health perception, such as perception of being seriously ill or too ill to return home (Q0300 - Q0600) | |
| <input type="checkbox"/> | • Clinical or functional change that may affect the resident's dignity, such as new or worsening incontinence, communication, or decline | |

| ✓ | Clinical issues that can cause or contribute to a mood problem | |
|--------------------------|-------------------------------------------------------------------------------------------------------------------------------|--|
| <input type="checkbox"/> | • Relapse of an underlying mental health problem (I5700 – I6100) | |
| <input type="checkbox"/> | • Psychiatric disorder (anxiety, depression, manic depression, schizophrenia, post-traumatic stress disorder) (I5700 – I6100) | |
| <input type="checkbox"/> | • Alzheimer's disease (I4200) | |
| <input type="checkbox"/> | • Delirium (C1600) | |
| <input type="checkbox"/> | • Delusions (E0100B) | |
| <input type="checkbox"/> | • Hallucinations (E0100A) | |
| <input type="checkbox"/> | • Communication problems (B0700, B0800) | |
| <input type="checkbox"/> | • Decline in Activities of Daily Living (ADLs) (G0110, clinical record) | |
| <input type="checkbox"/> | • Infection (I1700 – I2500, clinical record) | |
| <input type="checkbox"/> | • Pain (J0300 or J0800) | |
| <input type="checkbox"/> | • Cardiac disease (I0200 – I0900) | |
| <input type="checkbox"/> | • Thyroid abnormality (I3400) | |
| <input type="checkbox"/> | • Dehydration (J1550C, clinical record) | |
| <input type="checkbox"/> | • Metabolic disorder (I2900 – I3400) | |
| <input type="checkbox"/> | • Neurological disease (I4200 – I5500) | |
| <input type="checkbox"/> | • Recent cerebrovascular accident (I4500) | |
| <input type="checkbox"/> | • Dementia, cognitive decline (I4800, clinical record) | |
| <input type="checkbox"/> | • Cancer (I0100) | |
| <input type="checkbox"/> | • Other (I8000) | |

| | Medications (from medication administration record and preadmission records if new admission) | Supporting Documentation (Basis/reason for checking the item, including the location, date, and source (if applicable) of that information) |
|--------------------------|------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------|
| ✓ | | |
| <input type="checkbox"/> | • Antibiotics (N0410F) | |
| <input type="checkbox"/> | • Anticholinergics | |
| <input type="checkbox"/> | • Antihypertensives | |
| <input type="checkbox"/> | • Anticonvulsants | |
| <input type="checkbox"/> | • Antipsychotics (N0410A) | |
| <input type="checkbox"/> | • Cardiac medications | |
| <input type="checkbox"/> | • Cimetidine | |
| <input type="checkbox"/> | • Clonidine | |
| <input type="checkbox"/> | • Chemotherapeutic agents | |
| <input type="checkbox"/> | • Digitalis | |
| <input type="checkbox"/> | • Other | |
| <input type="checkbox"/> | • Glaucoma medications | |
| <input type="checkbox"/> | • Guanethidine | |
| <input type="checkbox"/> | • Immuno-suppressive medications | |
| <input type="checkbox"/> | • Methyldopa | |
| <input type="checkbox"/> | • Narcotics | |
| <input type="checkbox"/> | • Nitrates | |
| <input type="checkbox"/> | • Propranolol | |
| <input type="checkbox"/> | • Reserpine | |
| <input type="checkbox"/> | • Steroids | |
| <input type="checkbox"/> | • Stimulants | |

| ✓ | Laboratory tests | |
|--------------------------|-------------------------|--|
| <input type="checkbox"/> | • Serum calcium | |
| <input type="checkbox"/> | • Thyroid function | |
| <input type="checkbox"/> | • Blood glucose | |
| <input type="checkbox"/> | • Potassium | |
| <input type="checkbox"/> | • Porphyria | |

| |
|-------------------------------------------------------------------------------------------------------------------------------------------|
| Input from resident and/or family/representative regarding the care area. (Questions/Comments/Concerns/Preferences/Suggestions) |
| |

| Analysis of Findings | | Care Plan Considerations |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------|-----------------------------------------------------------|
| Review indicators and supporting documentation, and draw conclusions. Document: <ul style="list-style-type: none"> • Description of the problem; • Causes and contributing factors; and • Risk factors related to the care area. | Care Plan Y/N | Document reason(s) care plan will/ will not be developed. |
| | | |

Referral(s) to another discipline(s) is warranted (to whom and why): _____

Information regarding the CAA transferred to the CAA Summary (Section V of the MDS):

☐ Yes ☐ No

Signature/Title: _____ Date: _____

9. BEHAVIORAL SYMPTOMS**Review of Indicators of Behavioral Symptoms**

| ✓ | Seriousness of the behavioral symptoms (E0300, E0800, E0900, E1100) | Supporting Documentation (Basis/reason for checking the item, including the location, date, and source (if applicable) of that information) |
|--------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <input type="checkbox"/> | <ul style="list-style-type: none"> Resident is immediate threat to self – IMMEDIATE INTERVENTION REQUIRED (D0200I.1=1, D0500I.1=1, E1000 = 1) | |
| <input type="checkbox"/> | <ul style="list-style-type: none"> Resident is immediate threat to others – IMMEDIATE INTERVENTION REQUIRED (E0600A) | |

| ✓ | Nature of the behavioral disturbance (resident interview, if possible; staff observations) | |
|--------------------------|-------------------------------------------------------------------------------------------------------------------|--|
| <input type="checkbox"/> | <ul style="list-style-type: none"> Provoked or unprovoked | |
| <input type="checkbox"/> | <ul style="list-style-type: none"> Offensive or defensive | |
| <input type="checkbox"/> | <ul style="list-style-type: none"> Purposeful | |
| <input type="checkbox"/> | <ul style="list-style-type: none"> Occurs during specific activities, such as bath or transfers | |
| <input type="checkbox"/> | <ul style="list-style-type: none"> Pattern, such as certain times of the day, or varies over time | |
| <input type="checkbox"/> | <ul style="list-style-type: none"> Others in the vicinity are involved | |
| <input type="checkbox"/> | <ul style="list-style-type: none"> Reaction to a particular action, such as being physically moved | |
| <input type="checkbox"/> | <ul style="list-style-type: none"> Resident appears to startle easily | |

| ✓ | Medication side effects that can cause behavioral symptoms (from medication records) | Supporting Documentation (Basis/reason for checking the item, including the location, date, and source (if applicable) of that information) |
|--------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------|
| <input type="checkbox"/> | • New medication | |
| <input type="checkbox"/> | • Change in dosage | |
| <input type="checkbox"/> | • Antiparkinsonian drugs - may cause hypersexuality, socially inappropriate behavior | |
| <input type="checkbox"/> | • Sedatives, centrally active antihypertensives, some cardiac drugs, anticholinergic agents can cause paranoid delusions, delirium | |
| <input type="checkbox"/> | • Bronchodilators or other respiratory drugs, which can increase agitation and cause difficulty sleeping | |
| <input type="checkbox"/> | • Caffeine | |
| <input type="checkbox"/> | • Nicotine | |
| <input type="checkbox"/> | • Medications that impair impulse control, such as benzodiazepines, sedatives, alcohol (or any product containing alcohol, such as some cough medicine) | |

| ✓ | Illness or conditions that can cause behavior problems | |
|--------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|
| <input type="checkbox"/> | • Long-standing mental health problem associated with the behavioral disturbances, such as schizophrenia, bipolar disorder, depression, anxiety disorder, post-traumatic stress disorder (I5700 – I6100) | |
| <input type="checkbox"/> | • New or acute physical health problem or flare-up of a known chronic condition (I8000) | |
| <input type="checkbox"/> | • Delusions (E0100B) | |
| <input type="checkbox"/> | • Hallucinations (E0100A) | |
| <input type="checkbox"/> | • Paranoia (from record) | |
| <input type="checkbox"/> | • Constipation (H0600) | |
| <input type="checkbox"/> | • Congestive heart failure (I0600) | |
| <input type="checkbox"/> | • Infection (I1700 – I2500) | |
| <input type="checkbox"/> | • Head injury (I5500, clinical record) | |
| <input type="checkbox"/> | • Diabetes (I2900) | |
| <input type="checkbox"/> | • Pain (J0300, J0800) | |
| <input type="checkbox"/> | • Fever (J1550A, clinical record) | |
| <input type="checkbox"/> | • Dehydration (J1550C, clinical record; see Dehydration CAA) | |

| ✓ | Factors that can cause or exacerbate the behavior (from observation, interview, record) | Supporting Documentation (Basis/reason for checking the item, including the location, date, and source (if applicable) of that information) |
|--------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------|
| <input type="checkbox"/> | <ul style="list-style-type: none"> • Frustration due to problem communicating discomfort or unmet need | |
| <input type="checkbox"/> | <ul style="list-style-type: none"> • Frustration, agitation due to need to urinate or have bowel movement | |
| <input type="checkbox"/> | <ul style="list-style-type: none"> • Fear due to not recognizing caregiver | |
| <input type="checkbox"/> | <ul style="list-style-type: none"> • Fear due to not recognizing the environment or misinterpreting the environment or actions of others | |
| <input type="checkbox"/> | <ul style="list-style-type: none"> • Major unresolved sources of interpersonal conflict between the resident and family members, other residents, or staff (see Psychosocial Well-Being CAA) | |
| <input type="checkbox"/> | <ul style="list-style-type: none"> • Recent change, such as new admission (A1700) or a new unit, assignment of new care staff, or withdrawal from a treatment program | |
| <input type="checkbox"/> | <ul style="list-style-type: none"> • Departure from normal routines | |
| <input type="checkbox"/> | <ul style="list-style-type: none"> • Sleep disturbance (D0500C = 1) | |
| <input type="checkbox"/> | <ul style="list-style-type: none"> • Noisy, crowded area | |
| <input type="checkbox"/> | <ul style="list-style-type: none"> • Dimly lit area | |
| <input type="checkbox"/> | <ul style="list-style-type: none"> • Sensory impairment, such as hearing or vision problem (B0200, B1000) | |
| <input type="checkbox"/> | <ul style="list-style-type: none"> • Restraints (P0100) | |
| <input type="checkbox"/> | <ul style="list-style-type: none"> • Fatigue (D0500D = 1) | |
| <input type="checkbox"/> | <ul style="list-style-type: none"> • Need for repositioning (M1200) | |
| ✓ | Cognitive status problems (also see Cognitive Loss CAT/CAA) | |
| <input type="checkbox"/> | <ul style="list-style-type: none"> • Delirium (C1300), clinical record (Delirium CAT) | |
| <input type="checkbox"/> | <ul style="list-style-type: none"> • Dementia (I4800) | |
| <input type="checkbox"/> | <ul style="list-style-type: none"> • Recent cognitive loss (clinical record, interviews with family, etc.) | |
| <input type="checkbox"/> | <ul style="list-style-type: none"> • Alzheimer's disease (I4200) | |
| <input type="checkbox"/> | <ul style="list-style-type: none"> • Effects of cerebrovascular accident (I4500) | |

| ✓ | Other Considerations | Supporting Documentation (Basis/reason for checking the item, including the location, date, and source (if applicable) of that information) |
|--------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <input type="checkbox"/> | <ul style="list-style-type: none"> May be communicating discomfort, personal needs, preferences, fears, feeling ill | |
| <input type="checkbox"/> | <ul style="list-style-type: none"> Persons exhibiting long-standing problem behaviors related to psychiatric conditions may place others in danger of physical assault, intimidation, or embarrassment and place themselves at increased risk of being stigmatized, isolated, abused, and neglected by loved ones or care givers | |
| <input type="checkbox"/> | <ul style="list-style-type: none"> The actions and responses of family members and caregivers can aggravate or even cause behavioral outbursts | |

| |
|-------------------------------------------------------------------------------------------------------------------------------------------|
| Input from resident and/or family/representative regarding the care area. (Questions/Comments/Concerns/Preferences/Suggestions) |
| |

| Analysis of Findings | | Care Plan Considerations |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------|-----------------------------------------------------------|
| Review indicators and supporting documentation, and draw conclusions. Document: <ul style="list-style-type: none"> • Description of the problem; • Causes and contributing factors; and • Risk factors related to the care area. | Care Plan Y/N | Document reason(s) care plan will/ will not be developed. |
| | | |

Referral(s) to another discipline(s) is warranted (to whom and why): _____

Information regarding the CAA transferred to the CAA Summary (Section V of the MDS):

☐ Yes ☐ No

Signature/Title: _____ Date: _____

10. ACTIVITIES**Review of Indicators of Activities**

| ✓ | Activity preferences prior to admission (from interviews and clinical record) | Supporting Documentation (Basis/reason for checking the item, including the location, date, and source (if applicable) of that information) |
|--------------------------|-----------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <input type="checkbox"/> | • Passive | |
| <input type="checkbox"/> | • Active | |
| <input type="checkbox"/> | • Outside the home | |
| <input type="checkbox"/> | • Inside the home | |
| <input type="checkbox"/> | • Centered almost entirely on family activities | |
| <input type="checkbox"/> | • Centered almost entirely on non-family activities | |
| <input type="checkbox"/> | • Group (F0500E) activities | |
| <input type="checkbox"/> | • Solitary activities | |
| <input type="checkbox"/> | • Involved in community service, volunteer activities | |
| <input type="checkbox"/> | • Athletic | |
| <input type="checkbox"/> | • Non-athletic | |

| ✓ | Current activity pursuits (from interviews and clinical record) | |
|--------------------------|-----------------------------------------------------------------------------|--|
| <input type="checkbox"/> | • Resident identifies leisure activities of interest | |
| <input type="checkbox"/> | • Self-directed or done with others and/or planned by others | |
| <input type="checkbox"/> | • Activities resident pursues when visitors are present | |
| <input type="checkbox"/> | • Scheduled programs in which resident participates | |
| <input type="checkbox"/> | • Activities of interest not currently available or offered to the resident | |

| ✓ | Health issues that result in reduced activity participation | Supporting Documentation (Basis/reason for checking the item, including the location, date, and source (if applicable) of that information) |
|--------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------|
| <input type="checkbox"/> | <ul style="list-style-type: none"> Indicators of depression or anxiety (D0200, D0300, D0500, D0600) | |
| <input type="checkbox"/> | <ul style="list-style-type: none"> Use of psychoactive medications (N0410A-N0410D) | |
| <input type="checkbox"/> | <ul style="list-style-type: none"> Functional/mobility (G0110) or balance (G0300) problems; physical disability (G0300, G0400) | |
| <input type="checkbox"/> | <ul style="list-style-type: none"> Cognitive deficits (C0500, C0700-C1000), including stamina, ability to express self (B0700), understand others (B0800), make decisions (C1000) | |
| <input type="checkbox"/> | <ul style="list-style-type: none"> Unstable acute/chronic health problem (clinical record, O0100, J0100, J1100, J0700, J1400, J1550, I8000, M1040, M1200) | |
| <input type="checkbox"/> | <ul style="list-style-type: none"> Chronic health conditions, such as incontinence (H0300, H0400) or pain (J0300) | |
| <input type="checkbox"/> | <ul style="list-style-type: none"> Embarrassment or unease due to presence of equipment (O0100D, E, F), such as tubes, oxygen tank (O0100C), or colostomy bag (H0100) (observation, clinical record) | |
| <input type="checkbox"/> | <ul style="list-style-type: none"> Receives numerous treatments (O0100, O0400) that limit available time/energy (clinical record) | |
| <input type="checkbox"/> | <ul style="list-style-type: none"> Performs tasks slowly due to reduced energy reserves (observation, clinical record) | |

| ✓ | Environmental or staffing issues that hinder participation | |
|--------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|
| <input type="checkbox"/> | <ul style="list-style-type: none"> Physical barriers that prevent the resident from gaining access to the space where the activity is held (observation) | |
| <input type="checkbox"/> | <ul style="list-style-type: none"> Need for additional staff responsible for social activities (observation) | |
| <input type="checkbox"/> | <ul style="list-style-type: none"> Lack of staff time to involve residents in current activity programs (observation) | |
| <input type="checkbox"/> | <ul style="list-style-type: none"> Resident's fragile nature results in feelings of intimidation by staff responsible for the activity (from observation, interviews, clinical record) | |

| ✓ | Unique skills or knowledge the resident has that he or she could pass on to others (from interviews and clinical record) | Supporting Documentation (Basis/reason for checking the item, including the location, date, and source (if applicable) of that information) |
|--------------------------|---------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------|
| <input type="checkbox"/> | • Games | |
| <input type="checkbox"/> | • Complex tasks such as knitting, or computer skills | |
| <input type="checkbox"/> | • Topic that might interest others | |

| ✓ | Issues that result in reduced activity participation | |
|--------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|
| <input type="checkbox"/> | • Resident is new to facility or has been in facility long enough to become bored with status quo (interview, clinical record) | |
| <input type="checkbox"/> | • Psychosocial well-being issues, such as shyness, initiative, and social involvement | |
| <input type="checkbox"/> | • Socially inappropriate behavior (E0200) | |
| <input type="checkbox"/> | • Indicators of psychosis (E0100A-E0100C) | |
| <input type="checkbox"/> | • Feelings of being unwelcome, due to issues such as those already involved in an activity drawing boundaries that are difficult to cross (observation, interview, clinical record) | |
| <input type="checkbox"/> | • Limited opportunities for resident to get to know others through activities such as shared dining, afternoon refreshments, monthly birthday parties, reminiscence groups (observation, facility activity calendar) | |
| <input type="checkbox"/> | • Available activities do not correspond to resident's values, attitudes, expectations (interview, clinical record) (F0500, F0800) | |
| <input type="checkbox"/> | • Long history of unease in joining with others (interview, clinical record) | |

| |
|-------------------------------------------------------------------------------------------------------------------------------------------|
| Input from resident and/or family/representative regarding the care area. (Questions/Comments/Concerns/Preferences/Suggestions) |
| |

| Analysis of Findings | | Care Plan Considerations |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------|-----------------------------------------------------------|
| Review indicators and supporting documentation, and draw conclusions. Document: <ul style="list-style-type: none"> • Description of the problem; • Causes and contributing factors; and • Risk factors related to the care area. | Care Plan Y/N | Document reason(s) care plan will/ will not be developed. |
| | | |

Referral(s) to another discipline(s) is warranted (to whom and why): _____

Information regarding the CAA transferred to the CAA Summary (Section V of the MDS):

☐ Yes ☐ No

Signature/Title: _____ Date: _____

11. FALL(S)**Review of Indicators of Fall Risk**

| ✓ | History of falling (J1700, J1800, J1900) | Supporting Documentation (Basis/reason for checking the item, including the location, date, and source (if applicable) of that information) |
|--------------------------|----------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <input type="checkbox"/> | • Time of day, exact hour of the fall(s) | |
| <input type="checkbox"/> | • Location of the fall(s), such as bedroom, bathroom, hallway, stairs, outside, etc. | |
| <input type="checkbox"/> | • Related to specific medication | |
| <input type="checkbox"/> | • Proximity to most recent meal | |
| <input type="checkbox"/> | • Responding to bowel or bladder urgency | |
| <input type="checkbox"/> | • Doing usual/unusual activity | |
| <input type="checkbox"/> | • Standing still or walking | |
| <input type="checkbox"/> | • Reaching up or reaching down | |
| <input type="checkbox"/> | • Identify the conclusions about the root cause(s), contributing factors related to previous falls | |

| ✓ | Physical performance limitations: balance, gait, strength, muscle endurance (G0300A-G0300E) | |
|--------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------|--|
| <input type="checkbox"/> | • Difficulty maintaining sitting balance | |
| <input type="checkbox"/> | • Need to rock body or push off on arms of chair when standing up from chair | |
| <input type="checkbox"/> | • Difficulty maintaining standing position | |
| <input type="checkbox"/> | • Impaired balance during transitions (G0300A-G0300E) | |
| <input type="checkbox"/> | • Gait problem, such as unsteady gait, even with mobility aid or personal assistance, slow gait, takes small steps, takes rapid steps, or lurching gait | |
| <input type="checkbox"/> | • One leg appears shorter than the other | |
| <input type="checkbox"/> | • Musculoskeletal problem, such as kyphosis, weak hip flexors from extended bed rest, or shortening of a leg | |

| | | Supporting Documentation (Basis/reason for checking the item, including the location, date, and source (if applicable) of that information) |
|--------------------------|----------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|
| ✓ | Medications | |
| <input type="checkbox"/> | • Antipsychotics (N0410A) | |
| <input type="checkbox"/> | • Antianxiety agents (N0410B) | |
| <input type="checkbox"/> | • Antidepressants (N0410C) | |
| <input type="checkbox"/> | • Hypnotics (N0410D) | |
| <input type="checkbox"/> | • Cardiovascular medications (from medication administration record) | |
| <input type="checkbox"/> | • Diuretics (N0410G) (from medication administration record) | |
| <input type="checkbox"/> | • Narcotic analgesics (from medication administration record) | |
| <input type="checkbox"/> | • Neuroleptics (from medication administration record) | |
| <input type="checkbox"/> | • Other medications that cause lethargy or confusion (from medication administration record) | |

| | | |
|--------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|
| ✓ | Internal risk factors (from diagnosis list and clinical indicators) | |
| <input type="checkbox"/> | <ul style="list-style-type: none"> • Circulatory/Heart <ul style="list-style-type: none"> — Anemia (I0200) — Cardiac Dysrhythmias (I0300) — Angina, Myocardial Infarction (MI), Atherosclerotic Heart Disease (ASHD) (I0400) — Congestive Heart Failure (CHF) pulmonary edema (I0600) — Cerebrovascular Accident (CVA) (I4500) — Transient Ischemic Attack (TIA) (I4500) — Postural/Orthostatic hypotension (I0800) | |

(continued)

| ✓ | Internal risk factors (from diagnosis list and clinical indicators) (continued) | Supporting Documentation (Basis/reason for checking the item, including the location, date, and source (if applicable) of that information) |
|--------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------|
| <input type="checkbox"/> | <ul style="list-style-type: none"> • Neuromuscular/functional <ul style="list-style-type: none"> — Cerebral palsy (I4400) — Loss of arm or leg movement (G0400) — Decline in functional status (G0110) — Incontinence (H0300, H0400) — Hemiplegia/Hemiparesis (I4900) — Parkinson's disease (I5300) — Seizure disorder (I5400) — Paraplegia (I5000) — Multiple sclerosis (I5200) — Traumatic brain injury (I5500) — Syncope — Chronic or acute condition resulting in instability — Peripheral neuropathy — Muscle weakness | |
| <input type="checkbox"/> | <ul style="list-style-type: none"> • Orthopedic <ul style="list-style-type: none"> — Joint pain — Arthritis (I3700) — Osteoporosis (I3800) — Hip fracture (I3900) — Missing limb(s) (G0600D) | |
| <input type="checkbox"/> | <ul style="list-style-type: none"> • Perceptual <ul style="list-style-type: none"> — Visual impairment (B1000) — Hearing impairment (B0200) — Dizziness/vertigo | |
| <input type="checkbox"/> | <ul style="list-style-type: none"> • Psychiatric or cognitive <ul style="list-style-type: none"> — Impulsivity or poor safety awareness — Delirium (C1300) — Wandering (E0900) — Agitation behavior (E0200) – describe the specific verbal or motor activity- e.g. screaming, babbling, cursing, repetitive questions, pacing, kicking, scratching, etc. — Cognitive impairment (C0500, C0700-C1000) — Alzheimer's disease (I4200) — Other dementia (I4800) — Anxiety disorder (I5700) — Depression (I5800) — Manic depression (I5900) — Schizophrenia (I6000) | |

(continued)

| ✓ | Internal risk factors (from diagnosis list and clinical indicators) (continued) | Supporting Documentation (Basis/reason for checking the item, including the location, date, and source (if applicable) of that information) |
|--------------------------|----------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------|
| <input type="checkbox"/> | • Infection (I1700 – I2500) | |
| <input type="checkbox"/> | • Low levels of physical activity | |
| <input type="checkbox"/> | • Pain (J0300) | |
| <input type="checkbox"/> | • Headache | |
| <input type="checkbox"/> | • Fatigue, weakness | |
| <input type="checkbox"/> | • Vitamin D deficiency | |

| ✓ | Laboratory tests | |
|--------------------------|-----------------------------|--|
| <input type="checkbox"/> | • Hypo- or hyperglycemia | |
| <input type="checkbox"/> | • Electrolyte imbalance | |
| <input type="checkbox"/> | • Dehydration (J1550C) | |
| <input type="checkbox"/> | • Hemoglobin and hematocrit | |

| ✓ | Environmental factors (from review of facility environment) | |
|--------------------------|--------------------------------------------------------------------|--|
| <input type="checkbox"/> | • Poor lighting | |
| <input type="checkbox"/> | • Glare | |
| <input type="checkbox"/> | • Patterned carpet | |
| <input type="checkbox"/> | • Poorly arranged furniture | |
| <input type="checkbox"/> | • Uneven surfaces | |
| <input type="checkbox"/> | • Slippery floors | |
| <input type="checkbox"/> | • Obstructed walkway | |
| <input type="checkbox"/> | • Poor fitting or slippery shoes | |
| <input type="checkbox"/> | • Proximity to aggressive resident | |

| |
|-------------------------------------------------------------------------------------------------------------------------------------------|
| Input from resident and/or family/representative regarding the care area. (Questions/Comments/Concerns/Preferences/Suggestions) |
| |

| Analysis of Findings | | Care Plan Considerations |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------|-----------------------------------------------------------|
| Review indicators and supporting documentation, and draw conclusions. Document: <ul style="list-style-type: none"> • Description of the problem; • Causes and contributing factors; and • Risk factors related to the care area. | Care Plan Y/N | Document reason(s) care plan will/ will not be developed. |
| | | |

Referral(s) to another discipline(s) is warranted (to whom and why): _____

Information regarding the CAA transferred to the CAA Summary (Section V of the MDS):

☐ Yes ☐ No

Signature/Title: _____ Date: _____

12. NUTRITIONAL STATUS**Review of Indicators of Nutritional Status**

| ✓ | Current eating pattern – resident leaves significant proportion of meals, snacks, and supplements daily for even a few days | Supporting Documentation (Basis/reason for checking the item, including the location, date, and source (if applicable) of that information) |
|--------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------|
| <input type="checkbox"/> | <ul style="list-style-type: none"> Food offered or available is not consistent with the resident's food choices/needs <ul style="list-style-type: none"> — Food preferences not consistently honored — Resident has allergies or food intolerance (for example, needs lactose-free) — Food not congruent with religious or cultural needs — Resident complains about food quality (for example, not like what spouse used to prepare, food lacks flavor) — Resident doesn't eat processed foods — Food doesn't meet other special diet requirements | |
| <input type="checkbox"/> | <ul style="list-style-type: none"> Pattern re: food left uneaten (for example, usually leaves the meat or vegetables) | |
| <input type="checkbox"/> | <ul style="list-style-type: none"> Intervals between meals may be too long or too short | |
| <input type="checkbox"/> | <ul style="list-style-type: none"> Unwilling to accept food supplements or to eat more than three meals per day | |

| ✓ | Functional problems that affect ability to eat | Supporting Documentation (Basis/reason for checking the item, including the location, date, and source (if applicable) of that information) |
|--------------------------|-----------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------|
| <input type="checkbox"/> | • Swallowing problem (K0100) | |
| <input type="checkbox"/> | • Arthritis (I3700) | |
| <input type="checkbox"/> | • Contractures (G0400) | |
| <input type="checkbox"/> | • Functional limitation in range of motion (G0400) | |
| <input type="checkbox"/> | • Partial or total loss of arm movement (G0400A) | |
| <input type="checkbox"/> | • Hemiplegia/hemiparesis (I4900)(G0400 A and B = 1) | |
| <input type="checkbox"/> | • Quadriplegia/paraplegia (I5100/I5000) (G0400 A and/or B =2) | |
| <input type="checkbox"/> | • Inability to perform ADLs without significant physical assistance (G0110) | |
| <input type="checkbox"/> | • Inability to sit up (G0300) | |
| <input type="checkbox"/> | • Missing limb(s) (G0600D) | |
| <input type="checkbox"/> | • Vision problems (B1000) | |
| <input type="checkbox"/> | • Decreased ability to smell or taste food | |
| <input type="checkbox"/> | • Need for special diet or altered consistency which might not appeal to resident | |
| <input type="checkbox"/> | • Recent decline in Activities of Daily Living (ADLs) (G0110-G0600) | |

| ✓ | Cognitive, mental status, and behavior problems that can interfere with eating | |
|--------------------------|---------------------------------------------------------------------------------------|--|
| <input type="checkbox"/> | • Review Cognitive Loss CAA | |
| <input type="checkbox"/> | • Alzheimer's Disease (I4200) | |
| <input type="checkbox"/> | • Other dementia (I4800) | |
| <input type="checkbox"/> | • Intellectual disability/developmental disability (A1550) | |
| <input type="checkbox"/> | • Paranoid fear that food is poisoned | |
| <input type="checkbox"/> | • Requires frequent/constant cueing | |
| <input type="checkbox"/> | • Disruptive behaviors (E0200) | |
| <input type="checkbox"/> | • Indicators of psychosis (E0100) | |
| <input type="checkbox"/> | • Wandering (E0900) | |
| <input type="checkbox"/> | • Pacing (E0200) | |
| <input type="checkbox"/> | • Throwing food (E0200C) | |
| <input type="checkbox"/> | • Resisting care (E0800) | |
| <input type="checkbox"/> | • Very slow eating | |
| <input type="checkbox"/> | • Short attention span | |
| <input type="checkbox"/> | • Poor memory (C0500, C0700-C0900) | |
| <input type="checkbox"/> | • Anxiety problems (I5700) | |

| | | Supporting Documentation (Basis/reason for checking the item, including the location, date, and source (if applicable) of that information) |
|--------------------------|---------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|
| ✓ | Communication problems | |
| <input type="checkbox"/> | • Review Communication CAA | |
| <input type="checkbox"/> | • Comatose (B0100) | |
| <input type="checkbox"/> | • Difficulty making self understood (B0700) | |
| <input type="checkbox"/> | • Difficulty understanding others (B0800) | |
| <input type="checkbox"/> | • Aphasia (I4300) | |

| | | |
|--------------------------|--------------------------------------------------------------------------------------------|--|
| ✓ | Dental/oral problems (from Section L and physical assessment) | |
| <input type="checkbox"/> | • See Dental Care CAA | |
| <input type="checkbox"/> | • Broken or fractured teeth (L0200D) | |
| <input type="checkbox"/> | • Toothache (L0200F) | |
| <input type="checkbox"/> | • Bleeding gums (L0200E) | |
| <input type="checkbox"/> | • Loose dentures, dentures causing sores (L0200A) | |
| <input type="checkbox"/> | • Lip or mouth lesions (for example, cold sores, fever blisters, oral abscess) (L0200C) | |
| <input type="checkbox"/> | • Mouth pain (L0200F) | |
| <input type="checkbox"/> | • Dry mouth | |

| | | |
|--------------------------|---------------------------------------------------------------------------------------|--|
| ✓ | Other diseases and conditions that can affect appetite or nutritional needs | |
| <input type="checkbox"/> | • Anemia (I0200) | |
| <input type="checkbox"/> | • Arthritis (I3700) | |
| <input type="checkbox"/> | • Burns (M1040F) | |
| <input type="checkbox"/> | • Cancer (I0100) | |
| <input type="checkbox"/> | • Cardiovascular disease (I0300-I0900) | |
| <input type="checkbox"/> | • Cerebrovascular accident (I4500) | |
| <input type="checkbox"/> | • Constipation (H0600) | |
| <input type="checkbox"/> | • Delirium (C1600) | |
| <input type="checkbox"/> | • Depression (I5800) | |
| <input type="checkbox"/> | • Diabetes (I2900) | |
| <input type="checkbox"/> | • Diarrhea | |
| <input type="checkbox"/> | • Gastrointestinal problem (I1100-I1300) | |
| <input type="checkbox"/> | • Hospice care (O0100K) | |
| <input type="checkbox"/> | • Liver disease (I8000) | |
| <input type="checkbox"/> | • Pain (J0300) | |
| <input type="checkbox"/> | • Parkinson's disease (I5300) | |
| <input type="checkbox"/> | • Pressure ulcers (M0300) | |

(continued)

| ✓ | Other diseases and conditions that can affect appetite or nutritional needs (continued) | Supporting Documentation (Basis/reason for checking the item, including the location, date, and source (if applicable) of that information) |
|--------------------------|------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------|
| <input type="checkbox"/> | • Radiation therapy (O0100B) | |
| <input type="checkbox"/> | • Recent acute illness (I8000) | |
| <input type="checkbox"/> | • Recent surgical procedure (I8000) (M1200F) | |
| <input type="checkbox"/> | • Renal disease (I1500) | |
| <input type="checkbox"/> | • Respiratory disease (I6200) | |
| <input type="checkbox"/> | • Thyroid problem (I3400) | |
| <input type="checkbox"/> | • Weight loss (K0300) | |
| <input type="checkbox"/> | • Weight gain (K0310) | |

| ✓ | Abnormal laboratory values (from clinical record) | |
|--------------------------|----------------------------------------------------------|--|
| <input type="checkbox"/> | • Electrolytes | |
| <input type="checkbox"/> | • Pre-albumin level | |
| <input type="checkbox"/> | • Plasma transferrin level | |
| <input type="checkbox"/> | • Others | |

| ✓ | Medications (from medication administration record and preadmission records if new admission) | |
|--------------------------|------------------------------------------------------------------------------------------------------|--|
| <input type="checkbox"/> | • Antipsychotics (N0410A) | |
| <input type="checkbox"/> | • Chemotherapy (O0100A) | |
| <input type="checkbox"/> | • Cardiac drugs | |
| <input type="checkbox"/> | • Diuretics (N0410G) | |
| <input type="checkbox"/> | • Anti-inflammatory drug | |
| <input type="checkbox"/> | • Anti-Parkinson's drugs | |
| <input type="checkbox"/> | • Laxatives | |
| <input type="checkbox"/> | • Antacids | |
| <input type="checkbox"/> | • Start of a new drug | |

| ✓ | Environmental factors (from direct observation and clinical record) | |
|--------------------------|----------------------------------------------------------------------------|--|
| <input type="checkbox"/> | • Sufficient eating assistance | |
| <input type="checkbox"/> | • Availability of adaptive equipment | |
| <input type="checkbox"/> | • Dining environment fosters pleasant social experience | |
| <input type="checkbox"/> | • Appropriate lighting | |
| <input type="checkbox"/> | • Sufficient personal space during meals | |
| <input type="checkbox"/> | • Proper positioning in wheelchair/chair for dining | |

| |
|-------------------------------------------------------------------------------------------------------------------------------------------|
| Input from resident and/or family/representative regarding the care area. (Questions/Comments/Concerns/Preferences/Suggestions) |
| |

| Analysis of Findings | | Care Plan Considerations |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------|-----------------------------------------------------------|
| Review indicators and supporting documentation, and draw conclusions. Document: <ul style="list-style-type: none"> • Description of the problem; • Causes and contributing factors; and • Risk factors related to the care area. | Care Plan Y/N | Document reason(s) care plan will/ will not be developed. |
| | | |

Referral(s) to another discipline(s) is warranted (to whom and why): _____

Information regarding the CAA transferred to the CAA Summary (Section V of the MDS):

☐ Yes ☐ No

Signature/Title: _____ Date: _____

13. FEEDING TUBE(S)**Review of Indicators of Feeding Tubes**

| ✓ | Reason for tube feeding | Supporting Documentation (Basis/reason for checking the item, including the location, date, and source (if applicable) of that information) |
|--------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <input type="checkbox"/> | <ul style="list-style-type: none"> Unable to swallow or to eat food and unlikely to eat within a few days due to <ul style="list-style-type: none"> Physical problems in chewing or swallowing (for example, stroke or Parkinson's disease) (L0200F, K0100D) Mental problems (I5700 – I6100) (for example, Alzheimer's (I4200), depression (I5800)) | |
| <input type="checkbox"/> | <ul style="list-style-type: none"> Normal caloric intake is substantially impaired due to endotracheal tube or a tracheostomy (O0100E) | |
| <input type="checkbox"/> | <ul style="list-style-type: none"> Prevention of meal-induced hypoxemia (insufficient oxygen to blood), in resident with COPD (I6200) or other pulmonary problems that interfere with eating (I6200) | |

| ✓ | Complications of tube feeding | |
|--------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|
| <input type="checkbox"/> | <ul style="list-style-type: none"> Diagnostic conditions <ul style="list-style-type: none"> Delirium (C1600) Repetitive physical movements Anxiety (I5700, clinical record) Depression (I5800) Lung aspiration, pneumonia (I2000, clinical record) Infection at insertion site Shortness of breath (J1100) | |
| <input type="checkbox"/> | <ul style="list-style-type: none"> Bleeding around insertion site | |
| <input type="checkbox"/> | <ul style="list-style-type: none"> Constipation (H0600) | |
| <input type="checkbox"/> | <ul style="list-style-type: none"> Abdominal distension or abdominal pain | |
| <input type="checkbox"/> | <ul style="list-style-type: none"> Diarrhea or cramping | |
| <input type="checkbox"/> | <ul style="list-style-type: none"> Nausea, vomiting (J1550B) | |
| <input type="checkbox"/> | <ul style="list-style-type: none"> Tube dislodgement, blockage, leakage | |
| <input type="checkbox"/> | <ul style="list-style-type: none"> Bowel perforation | |
| <input type="checkbox"/> | <ul style="list-style-type: none"> Dehydration (J1550C) or fluid overload | |
| <input type="checkbox"/> | <ul style="list-style-type: none"> Self-extubation | |
| <input type="checkbox"/> | <ul style="list-style-type: none"> Use of physical restraints (P0100) | |

| | | Supporting Documentation (Basis/reason for checking the item, including the location, date, and source (if applicable) of that information) |
|--------------------------|------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------|
| ✓ | Psychosocial issues related to tube feeding | |
| <input type="checkbox"/> | • Signs of depression ((D0300, D0600, I5800); see Mood State CAA) | |
| <input type="checkbox"/> | • Ways to socially engage the resident with a feeding tube | |
| <input type="checkbox"/> | • Emotional and social support from social workers, other members of the healthcare team | |

| | | |
|--------------------------|---------------------------------------------------------------------------------------------------------------------------|--|
| ✓ | Periodic evaluations and consultations | |
| <input type="checkbox"/> | • Weight check at least monthly (K0300, K0310) | |
| <input type="checkbox"/> | • Lab tests to monitor electrolytes, serum albumin, hematocrit | |
| <input type="checkbox"/> | • Periodic evaluations by nutritionist or dietitian | |
| <input type="checkbox"/> | • Periodic evaluation of possibility of resuming oral feeding | |
| <input type="checkbox"/> | • Regular changing and replacement of PEG tubes and J-tubes, per physician order and facility protocol (K0510B1, K0510B2) | |

| | | |
|--------------------------|------------------------------------------------------------------------------|--|
| ✓ | Factors that may impede removal of feeding tube | |
| <input type="checkbox"/> | • Comatose (B0100) | |
| <input type="checkbox"/> | • Failure to eat and resists assistance in eating (E0800) | |
| <input type="checkbox"/> | • Cerebrovascular accident (I4500) | |
| <input type="checkbox"/> | • Gastric ulcers, gastric bleeding, or other stomach disorder (I1200, I1300) | |
| <input type="checkbox"/> | • Chewing problems unresolvable (L0200F) | |
| <input type="checkbox"/> | • Swallowing problems (K0100) unresolvable | |
| <input type="checkbox"/> | • Mouth pain (L0200F) | |
| <input type="checkbox"/> | • Anorexia (I8000) | |
| <input type="checkbox"/> | • Lab values indicating compromised nutritional status | |
| <input type="checkbox"/> | • Significant weight loss (K0300) | |
| <input type="checkbox"/> | • Significant weight gain (K0310) | |
| <input type="checkbox"/> | • Prolonged illness | |
| <input type="checkbox"/> | • Neurological disorder (I4200 – I5500) | |
| <input type="checkbox"/> | • Cancer or side effects of cancer treatment (I0100, clinical record) | |
| <input type="checkbox"/> | • Advanced dementia (I4800) | |

| |
|-------------------------------------------------------------------------------------------------------------------------------------------|
| Input from resident and/or family/representative regarding the care area. (Questions/Comments/Concerns/Preferences/Suggestions) |
| |

| Analysis of Findings | | Care Plan Considerations |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------|-----------------------------------------------------------|
| Review indicators and supporting documentation, and draw conclusions. Document: <ul style="list-style-type: none"> • Description of the problem; • Causes and contributing factors; and • Risk factors related to the care area. | Care Plan Y/N | Document reason(s) care plan will/ will not be developed. |
| | | |

Referral(s) to another discipline(s) is warranted (to whom and why): _____

Information regarding the CAA transferred to the CAA Summary (Section V of the MDS):

☐ Yes ☐ No

Signature/Title: _____ Date: _____

14. DEHYDRATION/FLUID MAINTENANCE**Review of Indicators of Dehydration/Fluid Maintenance**

| ✓ | Symptoms of dehydration | Supporting Documentation (Basis/reason for checking the item, including the location, date, and source (if applicable) of that information) |
|--------------------------|----------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <input type="checkbox"/> | • Dizziness on sitting or standing | |
| <input type="checkbox"/> | • Confusion or change in mental status (delirium) (C1600, V0100D) | |
| <input type="checkbox"/> | • Lethargy (C1300C) | |
| <input type="checkbox"/> | • Recent decrease in urine volume or more concentrated urine than usual | |
| <input type="checkbox"/> | • Decreased skin turgor, dry mucous membranes (J1550) | |
| <input type="checkbox"/> | • Newly present constipation (H0600), fecal impaction | |
| <input type="checkbox"/> | • Fever (J1550A) | |
| <input type="checkbox"/> | • Functional decline (G0110) | |
| <input type="checkbox"/> | • Increased risk for falls (J1700) | |
| <input type="checkbox"/> | • Fluid and electrolyte disturbance | |

| ✓ | Abnormal laboratory values (from clinical record) | |
|--------------------------|-------------------------------------------------------------|--|
| <input type="checkbox"/> | • Hemoglobin | |
| <input type="checkbox"/> | • Hematocrit | |
| <input type="checkbox"/> | • Potassium chloride | |
| <input type="checkbox"/> | • Sodium | |
| <input type="checkbox"/> | • Albumin | |
| <input type="checkbox"/> | • Blood urea nitrogen | |
| <input type="checkbox"/> | • Urine specific gravity | |

| ✓ | Cognitive, communication, and mental status issues that can interfere with intake | Supporting Documentation (Basis/reason for checking the item, including the location, date, and source (if applicable) of that information) |
|--------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------|
| <input type="checkbox"/> | • Depression (I5800, D0300, D0600) or anxiety (I5700) | |
| <input type="checkbox"/> | • Behavioral disturbance that interferes with intake (E0200, clinical record) | |
| <input type="checkbox"/> | • Recent change in mental status (C1600) | |
| <input type="checkbox"/> | • Alzheimer's or other dementia that interferes with eating due to short attention span, resisting assistance, slow eating/drinking, etc. (I4200, I4800) | |
| <input type="checkbox"/> | • Difficulty making self understood (B0700) | |
| <input type="checkbox"/> | • Difficulty understanding others (B0800) | |

| ✓ | Diseases and conditions that predispose to limitations in maintaining normal fluid balance | |
|--------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|
| <input type="checkbox"/> | • Infection (I1700 – I2500) | |
| <input type="checkbox"/> | • Fever (J1550A) | |
| <input type="checkbox"/> | • Diabetes (I2900) | |
| <input type="checkbox"/> | • Congestive heart failure (I0600) | |
| <input type="checkbox"/> | • Swallow problem (K0100) | |
| <input type="checkbox"/> | • Renal disease (I1500) | |
| <input type="checkbox"/> | • Weight loss (K0300) | |
| <input type="checkbox"/> | • Weight gain (K0310) | |
| <input type="checkbox"/> | • New cerebrovascular accident (clinical record, I4500) | |
| <input type="checkbox"/> | • Unstable acute or chronic condition (clinical record, I8000) | |
| <input type="checkbox"/> | • Nausea or vomiting (J1550B) | |
| <input type="checkbox"/> | • Diarrhea (clinical record) | |
| <input type="checkbox"/> | • Excessive sweating (clinical record) | |
| <input type="checkbox"/> | • Recent surgery (clinical record, I8000) | |
| <input type="checkbox"/> | • Recent decline in activities of daily living (G0110), including body control or hand control problems, inability to sit up (G0300), etc. (observation, interview, clinical record) | |
| <input type="checkbox"/> | • Parkinson's or other neurological disease that requires unusually long time to eat (I4200 – I5500) | |
| <input type="checkbox"/> | • Abdominal pain, with or without diarrhea, nausea, or vomiting (clinical record, J1550B) | |

(continued)

| ✓ | Diseases and conditions that predispose to limitations in maintaining normal fluid balance (continued) | Supporting Documentation (Basis/reason for checking the item, including the location, date, and source (if applicable) of that information) |
|--------------------------|---------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------|
| <input type="checkbox"/> | <ul style="list-style-type: none"> Newly taking a diuretic or recent increase in diuretic dose (N0410G) (medication records) | |
| <input type="checkbox"/> | <ul style="list-style-type: none"> Takes excessive doses of a laxative (interview, clinical record) | |
| <input type="checkbox"/> | <ul style="list-style-type: none"> Hot weather (increases risk for elderly in absence of increased fluid intake) | |

| ✓ | Oral intake (from observation and clinical record) | |
|--------------------------|---------------------------------------------------------------------------------------------------------|--|
| <input type="checkbox"/> | <ul style="list-style-type: none"> Recent change in oral intake | |
| <input type="checkbox"/> | <ul style="list-style-type: none"> Skips meals or consumes less than 25 percent of meals | |
| <input type="checkbox"/> | <ul style="list-style-type: none"> Fluid restriction | |
| <input type="checkbox"/> | <ul style="list-style-type: none"> Newly prescribed diet | |
| <input type="checkbox"/> | <ul style="list-style-type: none"> Decreased perception of thirst | |
| <input type="checkbox"/> | <ul style="list-style-type: none"> Limited fluid-drinking opportunities | |
| <input type="checkbox"/> | <ul style="list-style-type: none"> Fluid intake limited to try to control incontinence | |
| <input type="checkbox"/> | <ul style="list-style-type: none"> Dependence on staff for fluid intake | |
| <input type="checkbox"/> | <ul style="list-style-type: none"> Excessive output compared to fluid intake | |

| |
|-------------------------------------------------------------------------------------------------------------------------------------------|
| Input from resident and/or family/representative regarding the care area. (Questions/Comments/Concerns/Preferences/Suggestions) |
| |

| Analysis of Findings | | Care Plan Considerations |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------|-----------------------------------------------------------|
| Review indicators and supporting documentation, and draw conclusions. Document: <ul style="list-style-type: none"> • Description of the problem; • Causes and contributing factors; and • Risk factors related to the care area. | Care Plan Y/N | Document reason(s) care plan will/ will not be developed. |
| | | |

Referral(s) to another discipline(s) is warranted (to whom and why): _____

Information regarding the CAA transferred to the CAA Summary (Section V of the MDS):

☐ Yes ☐ No

Signature/Title: _____ Date: _____

15. DENTAL CARE**Review of Indicators of Oral/Dental Condition/Problem**

| | | Supporting Documentation (Basis/reason for checking the item, including the location, date, and source (if applicable) of that information) |
|--------------------------|----------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|
| ✓ | Cognitive problems that contribute to oral/dental problems | |
| <input type="checkbox"/> | • Needs reminders to clean teeth | |
| <input type="checkbox"/> | • Cannot remember steps to complete oral hygiene | |
| <input type="checkbox"/> | • Decreased ability to understand others (B0800) or to perform tasks following demonstration | |
| <input type="checkbox"/> | • Cognitive deficit (C0500, C0700 – C1000) | |

| | | |
|--------------------------|------------------------------------------------------------------------------|--|
| ✓ | Functional impairment limiting ability to perform personal hygiene | |
| <input type="checkbox"/> | • Loss of voluntary arm movement (G0400A) | |
| <input type="checkbox"/> | • Impaired hand dexterity (G0400A) | |
| <input type="checkbox"/> | • Functional limitation in upper extremity range of motion (G0400A) | |
| <input type="checkbox"/> | • Decreased mobility (G0110) | |
| <input type="checkbox"/> | • Resists assistance with activities of daily living (E0800) | |
| <input type="checkbox"/> | • Lacks motivation or knowledge regarding adequate oral hygiene, dental care | |
| <input type="checkbox"/> | • Requires adaptive equipment for oral hygiene | |

| | | |
|--------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|
| ✓ | Dry mouth causing buildup of oral bacteria | |
| <input type="checkbox"/> | • Dehydration (see Dehydration/Fluid Maintenance CAA) | |
| <input type="checkbox"/> | • Medications (from MDS and medication administration record) — Antipsychotics (N0410A) — Antidepressants (N0410C) — Antianxiety agents (N0410B) — Sedatives/hypnotics (N0410D) — Diuretics (N0410G) — Antihypertensives — Antiparkinsons medications — Narcotics — Anticonvulsants — Antihistamines — Decongestants — Antiemetics | |
| <input type="checkbox"/> | • Antineoplastics | |

| ✓ | Diseases and conditions that may be related to poor oral hygiene, oral infection | Supporting Documentation (Basis/reason for checking the item, including the location, date, and source (if applicable) of that information) |
|--------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------|
| <input type="checkbox"/> | <ul style="list-style-type: none"> Recurrent pneumonia related to aspiration of saliva contaminated due to poor oral hygiene (I2000) | |
| <input type="checkbox"/> | <ul style="list-style-type: none"> Unstable diabetes related to oral infection (I2900) | |
| <input type="checkbox"/> | <ul style="list-style-type: none"> Endocarditis related to oral infection (I8000) | |
| <input type="checkbox"/> | <ul style="list-style-type: none"> Sores in mouth related to poor-fitting dentures (L0200C) | |
| <input type="checkbox"/> | <ul style="list-style-type: none"> Poor nutrition (I5600) (See Nutrition CAA) | |

| |
|-------------------------------------------------------------------------------------------------------------------------------------------|
| Input from resident and/or family/representative regarding the care area. (Questions/Comments/Concerns/Preferences/Suggestions) |
| |

| Analysis of Findings | | Care Plan Considerations |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------|-----------------------------------------------------------|
| Review indicators and supporting documentation, and draw conclusions. Document: <ul style="list-style-type: none"> • Description of the problem; • Causes and contributing factors; and • Risk factors related to the care area. | Care Plan Y/N | Document reason(s) care plan will/ will not be developed. |
| | | |

Referral(s) to another discipline(s) is warranted (to whom and why): _____

Information regarding the CAA transferred to the CAA Summary (Section V of the MDS):

☐ Yes ☐ No

Signature/Title: _____ Date: _____

16. PRESSURE ULCER(S)**Review of Indicators of Pressure Ulcer(s)**

| ✓ | Existing pressure ulcer(s) (M0100) | Supporting Documentation (Basis/reason for checking the item, including the location, date, and source (if applicable) of that information) |
|--------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <input type="checkbox"/> | <ul style="list-style-type: none"> Assess location, size, stage, presence and type of drainage, presence of odors, condition of surrounding skin (M0610) <ul style="list-style-type: none"> Note if eschar or slough is present (M0300F, M0700 = 4) Assess for signs of infection, such as the presence of a foul odor, increasing pain, surrounding skin is reddened (erythema) or warm, or there is a presence of purulent drainage Note whether granulation tissue (required for healing) is present and the wound is healing as expected (M0700 = 2) | |
| <input type="checkbox"/> | <ul style="list-style-type: none"> If the ulcer does not show signs of healing despite treatment, consider complicating factors <ul style="list-style-type: none"> Elevated bacterial level in the absence of clinical infection Presence of exudate, necrotic debris or slough in the wound, too much granulation tissue, or odor in the wound bed Underlying osteomyelitis (bone infection) | |
| ✓ | Extrinsic risk factors | |
| <input type="checkbox"/> | <ul style="list-style-type: none"> Pressure <ul style="list-style-type: none"> Requires staff assistance to move sufficiently to relieve pressure over any one site Confined to a bed or chair all or most of the time Needs special mattress or seat cushion to reduce or relieve pressure (M1200A, M1200B) Requires regular schedule of turning (M1200C) | |
| <input type="checkbox"/> | <ul style="list-style-type: none"> Friction and shear <ul style="list-style-type: none"> Slides down in the bed Moved by sliding rather than lifting | |
| <input type="checkbox"/> | <ul style="list-style-type: none"> Maceration <ul style="list-style-type: none"> Persistently wet, especially from fecal incontinence, wound drainage, or perspiration Moisture associated skin damage (M1040H) | |

| | | Supporting Documentation (Basis/reason for checking the item, including the location, date, and source (if applicable) of that information) |
|--------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|
| ✓ | Intrinsic risk factors | |
| <input type="checkbox"/> | • Immobility (G0110) | |
| <input type="checkbox"/> | • Altered mental status — Delirium limits mobility (see Delirium CAA) — Cognitive loss (C0500, C0700-C1000) limits mobility (see Cognitive Loss CAA) | |
| <input type="checkbox"/> | • Incontinence (H0300, H0400, M1040H) (see Incontinence CAA) | |
| <input type="checkbox"/> | • Poor nutrition (see Nutrition CAA) | |

| | | |
|--------------------------|----------------------------------------------------------------------|--|
| ✓ | Medications that increase risk for pressure ulcer development | |
| <input type="checkbox"/> | • Antipsychotics (N0410A) | |
| <input type="checkbox"/> | • Antianxiety agents (N0410B) | |
| <input type="checkbox"/> | • Antidepressants (N0410C) | |
| <input type="checkbox"/> | • Hypnotics (N0410D) | |
| <input type="checkbox"/> | • Steroids | |
| <input type="checkbox"/> | • Narcotics | |

| | | |
|--------------------------|-------------------------------------------------------------------------------------------------|--|
| ✓ | Diagnoses and conditions that present complications or increase risk for pressure ulcers | |
| <input type="checkbox"/> | • Delirium (C1600) | |
| <input type="checkbox"/> | • Comatose (B0100) | |
| <input type="checkbox"/> | • Cancer (I0100) | |
| <input type="checkbox"/> | • Peripheral Vascular Disease (I0900) | |
| <input type="checkbox"/> | • Diabetes (I2900) | |
| <input type="checkbox"/> | • Alzheimer's disease (I4200) | |
| <input type="checkbox"/> | • Cerebrovascular Accident (I4500) | |
| <input type="checkbox"/> | • Other dementia (I4800) | |
| <input type="checkbox"/> | • Hemiplegia/hemiparesis (I4900) | |
| <input type="checkbox"/> | • Paraplegia (I5000), Quadriplegia (I5100) | |
| <input type="checkbox"/> | • Multiple sclerosis (I5200) | |
| <input type="checkbox"/> | • Depression (D0300, D0600, I5800) | |
| <input type="checkbox"/> | • Edema | |
| <input type="checkbox"/> | • Severe pulmonary disease (I6200) | |
| <input type="checkbox"/> | • Sepsis (I2100) | |
| <input type="checkbox"/> | • Terminal illness (O0100K) | |

(continued)

| ✓ | Diagnoses and conditions that present complications or increase risk for pressure ulcers (continued) | Supporting Documentation (Basis/reason for checking the item, including the location, date, and source (if applicable) of that information) |
|--------------------------|-------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------|
| <input type="checkbox"/> | • Chronic or end-stage renal (I1500) , liver, or heart disease (I0400, I0600) | |
| <input type="checkbox"/> | • Pain (J0300) | |
| <input type="checkbox"/> | • Dehydration (J1500C, I8000) | |
| <input type="checkbox"/> | • Shortness of breath (J1100) | |
| <input type="checkbox"/> | • Recent weight loss (K0300) | |
| <input type="checkbox"/> | • Recent weight gain (K0310) | |
| <input type="checkbox"/> | • Malnutrition (I5600) | |
| <input type="checkbox"/> | • Decreased sensory perception | |
| <input type="checkbox"/> | • Recent decline in Activities of Daily Living (ADLs) (G0110-G0600) | |

| ✓ | Treatments and other factors that cause complications or increase risk | |
|--------------------------|--------------------------------------------------------------------------------------------------------------------------------|--|
| <input type="checkbox"/> | • Newly admitted or readmitted (A1700) | |
| <input type="checkbox"/> | • History of healed pressure ulcer(s) (M0900) | |
| <input type="checkbox"/> | • Chemotherapy (O0100A) | |
| <input type="checkbox"/> | • Radiation therapy (O0100B) | |
| <input type="checkbox"/> | • Ventilator or respirator (O0100F) | |
| <input type="checkbox"/> | • Renal dialysis (O0100J) | |
| <input type="checkbox"/> | • Functional limitation in range of motion (G0400) | |
| <input type="checkbox"/> | • Head of bed elevated most or all of the time | |
| <input type="checkbox"/> | • Physical restraints (P0100) | |
| <input type="checkbox"/> | • Devices that can cause pressure, such as oxygen (O0100C) or indwelling catheter (H0100A) tubing, TED hose, casts, or splints | |

| |
|-------------------------------------------------------------------------------------------------------------------------------------------|
| Input from resident and/or family/representative regarding the care area. (Questions/Comments/Concerns/Preferences/Suggestions) |
| |

| Analysis of Findings | | Care Plan Considerations |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------|-----------------------------------------------------------|
| Review indicators and supporting documentation, and draw conclusions. Document: <ul style="list-style-type: none"> • Description of the problem; • Causes and contributing factors; and • Risk factors related to the care area. | Care Plan Y/N | Document reason(s) care plan will/ will not be developed. |
| | | |

Referral(s) to another discipline(s) is warranted (to whom and why): _____

Information regarding the CAA transferred to the CAA Summary (Section V of the MDS):

☐ Yes ☐ No

Signature/Title: _____ Date: _____

17. PSYCHOTROPIC MEDICATION USE**Review of Indicators of Psychotropic Drug Use**

| ✓ | Class(es) of medication this resident is taking | Supporting Documentation (Basis/reason for checking the item, including the location, date, and source (if applicable) of that information) |
|--------------------------|--------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------|
| <input type="checkbox"/> | • Antipsychotic (N0410A) | |
| <input type="checkbox"/> | • Antianxiety (N0410B) | |
| <input type="checkbox"/> | • Antidepressant (N0410C) | |
| <input type="checkbox"/> | • Sedative/Hypnotic (N0410D) | |

| ✓ | Unnecessary drug evaluation (from clinical record) | |
|--------------------------|-----------------------------------------------------------------------|--|
| <input type="checkbox"/> | • Excessive dose, including duplicate medications | |
| <input type="checkbox"/> | • Excessive duration and/or without gradual dose reductions | |
| <input type="checkbox"/> | • Inadequate monitoring for effectiveness and/or adverse consequences | |
| <input type="checkbox"/> | • Inadequate or inappropriate indications for use | |
| <input type="checkbox"/> | • In presence of adverse consequences of the drug | |

| ✓ | Treatable/reversible reasons for use of psychotropic drug | |
|--------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------|--|
| <input type="checkbox"/> | • Environmental stressors such as excessive heat, noise, overcrowding, etc. (observation, clinical record) | |
| <input type="checkbox"/> | • Psychosocial stressors such as abuse, taunting, not following resident's customary routine, etc. (observation, clinical record) (F0300 – F0800) | |
| <input type="checkbox"/> | • Treatable medical conditions, such as heart disease (I0200 – I0900) , diabetes (I2900), or respiratory disease (from medical evaluation) (I6200, I6300) | |

| ✓ | Adverse consequences of ANTIDEPRESSANTS exhibited by this resident | Supporting Documentation (Basis/reason for checking the item, including the location, date, and source (if applicable) of that information) |
|--------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <input type="checkbox"/> | <ul style="list-style-type: none"> Worsening of depression and/or suicidal behavior or thinking (D0350, D0650, V0100E, V0100F, clinical record) | |
| <input type="checkbox"/> | <ul style="list-style-type: none"> Delirium unrelated to medical illness or severe depression (C1600, clinical record) | |
| <input type="checkbox"/> | <ul style="list-style-type: none"> Hallucinations (E0100A) | |
| <input type="checkbox"/> | <ul style="list-style-type: none"> Dizziness (clinical record) | |
| <input type="checkbox"/> | <ul style="list-style-type: none"> Nausea (clinical record) | |
| <input type="checkbox"/> | <ul style="list-style-type: none"> Diarrhea (clinical record) | |
| <input type="checkbox"/> | <ul style="list-style-type: none"> Anxiety (I5700, clinical record) | |
| <input type="checkbox"/> | <ul style="list-style-type: none"> Nervousness, fidgety or restless (clinical record) | |
| <input type="checkbox"/> | <ul style="list-style-type: none"> Insomnia (clinical record) | |
| <input type="checkbox"/> | <ul style="list-style-type: none"> Somnolence (clinical record) | |
| <input type="checkbox"/> | <ul style="list-style-type: none"> Weight gain (K0310, clinical record) | |
| <input type="checkbox"/> | <ul style="list-style-type: none"> Anorexia or increased appetite (clinical record) | |
| <input type="checkbox"/> | <ul style="list-style-type: none"> Increased risk for falls (clinical record), falls (J1700-J1900) | |
| <input type="checkbox"/> | <ul style="list-style-type: none"> Seizures (I5400) | |
| <input type="checkbox"/> | <ul style="list-style-type: none"> Hypertensive crisis if combined with certain foods, cheese, wine (MAO inhibitors) | |
| <input type="checkbox"/> | <ul style="list-style-type: none"> Anticholinergic (tricyclics), such as constipation, dry mouth, blurred vision, urinary retention, etc. (clinical record) | |
| <input type="checkbox"/> | <ul style="list-style-type: none"> Postural hypotension (tricyclics) (I0800, clinical record) | |

| ✓ | Adverse consequences of ANTIPSYCHOTICS exhibited by this resident | |
|--------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|
| <input type="checkbox"/> | <ul style="list-style-type: none"> Anticholinergic effects, such as constipation, dry mouth, blurred vision, urinary retention, etc. (clinical record) | |
| <input type="checkbox"/> | <ul style="list-style-type: none"> Increase in total cholesterol and triglycerides (clinical record) | |
| <input type="checkbox"/> | <ul style="list-style-type: none"> Akathisia (inability to sit still) (clinical record) | |
| <input type="checkbox"/> | <ul style="list-style-type: none"> Parkinsonism (any combination of tremors, postural unsteadiness, muscle rigidity, pill-rolling of hands, shuffling gait, etc.) (clinical record) | |

(continued)

| ✓ | Adverse consequences of ANTIPSYCHOTICS exhibited by this resident | Supporting Documentation (Basis/reason for checking the item, including the location, date, and source (if applicable) of that information) |
|--------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------|
| <input type="checkbox"/> | <ul style="list-style-type: none"> • Neuroleptic malignant syndrome (high fever with severe muscular rigidity) (clinical record) | |
| <input type="checkbox"/> | <ul style="list-style-type: none"> • Blood sugar elevation (clinical record) | |
| <input type="checkbox"/> | <ul style="list-style-type: none"> • Cardiac arrhythmias (I0300) | |
| <input type="checkbox"/> | <ul style="list-style-type: none"> • Orthostatic hypotension (I0800, clinical record) | |
| <input type="checkbox"/> | <ul style="list-style-type: none"> • Cerebrovascular accident or transient ischemic attack (I4500) | |
| <input type="checkbox"/> | <ul style="list-style-type: none"> • Falls (J1700-J1900) | |
| <input type="checkbox"/> | <ul style="list-style-type: none"> • Tardive dyskinesia (persistent involuntary movements such as tongue thrusting, lip movements, chewing or puckering movements, abnormal limb movements, rocking or writhing trunk movements) (clinical record) | |
| <input type="checkbox"/> | <ul style="list-style-type: none"> • Lethargy (D0200D, clinical record) | |
| <input type="checkbox"/> | <ul style="list-style-type: none"> • Excessive sedation (clinical record) | |
| <input type="checkbox"/> | <ul style="list-style-type: none"> • Depression (D0300, D0600, I5800) | |
| <input type="checkbox"/> | <ul style="list-style-type: none"> • Hallucinations (E0100A) | |
| <input type="checkbox"/> | <ul style="list-style-type: none"> • Delirium unrelated to medical illness or severe depression (C1600, clinical record) | |

| ✓ | Adverse consequences of ANXIOLYTICS exhibited by this resident | |
|--------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|
| <input type="checkbox"/> | <ul style="list-style-type: none"> • Sedation manifested by short-term memory loss (C0500, C0700), decline in cognitive abilities, slurred speech (B0600), drowsiness, little/no activity involvement (clinical record) | |
| <input type="checkbox"/> | <ul style="list-style-type: none"> • Delirium unrelated to medical illness or severe depression (C1600, clinical record) | |
| <input type="checkbox"/> | <ul style="list-style-type: none"> • Hallucinations (E0100A) | |
| <input type="checkbox"/> | <ul style="list-style-type: none"> • Depression (D0300, D0600, I5800) | |
| <input type="checkbox"/> | <ul style="list-style-type: none"> • Disturbances of balance, gait, positioning ability (G0300, G0110C, G0110D, G0110A, clinical record) | |

| ✓ | Adverse consequences of SEDATIVES/HYPNOTICS exhibited by this resident | Supporting Documentation (Basis/reason for checking the item, including the location, date, and source (if applicable) of that information) |
|--------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------|
| <input type="checkbox"/> | <ul style="list-style-type: none"> May increase the metabolism of many medications (for example, anticonvulsants, antipsychotics), which may lead to decreased effectiveness and subsequent worsening of symptoms or decreased control of underlying illness (clinical record) | |
| <input type="checkbox"/> | <ul style="list-style-type: none"> Hypotension (I0800, clinical record) | |
| <input type="checkbox"/> | <ul style="list-style-type: none"> Dizziness, lightheadedness (clinical record) | |
| <input type="checkbox"/> | <ul style="list-style-type: none"> “Hangover” effect (interview, clinical record) | |
| <input type="checkbox"/> | <ul style="list-style-type: none"> Drowsiness (observation, clinical record) | |
| <input type="checkbox"/> | <ul style="list-style-type: none"> Confusion, delirium unrelated to acute illness or severe depression (C1600, clinical record) | |
| <input type="checkbox"/> | <ul style="list-style-type: none"> Mental depression (I5800, I5900) | |
| <input type="checkbox"/> | <ul style="list-style-type: none"> Unusual excitement (clinical record) | |
| <input type="checkbox"/> | <ul style="list-style-type: none"> Nervousness (clinical record) | |
| <input type="checkbox"/> | <ul style="list-style-type: none"> Headache (interview, clinical record) | |
| <input type="checkbox"/> | <ul style="list-style-type: none"> Insomnia (clinical record) | |
| <input type="checkbox"/> | <ul style="list-style-type: none"> Nightmares (interview, clinical record) | |
| <input type="checkbox"/> | <ul style="list-style-type: none"> Hallucinations (E0100A) | |
| <input type="checkbox"/> | <ul style="list-style-type: none"> Falls (J1700-J1900) | |

| ✓ | Drug-related discomfort requiring treatment and/or prevention | |
|--------------------------|----------------------------------------------------------------------------------------------------------|--|
| <input type="checkbox"/> | <ul style="list-style-type: none"> Dehydration (J1550C, I8000) | |
| <input type="checkbox"/> | <ul style="list-style-type: none"> Reduced dietary bulk (from observation of food intake) | |
| <input type="checkbox"/> | <ul style="list-style-type: none"> Lack of exercise (observation, clinical record) | |
| <input type="checkbox"/> | <ul style="list-style-type: none"> Constipation/fecal impaction (H0600, clinical record) | |
| <input type="checkbox"/> | <ul style="list-style-type: none"> Urinary retention (clinical record) | |
| <input type="checkbox"/> | <ul style="list-style-type: none"> Dry mouth (interview, clinical record) | |

| ✓ | Overall status change for relationship to psychotropic drug use (from clinical record) | |
|--------------------------|--------------------------------------------------------------------------------------------------------|--|
| <input type="checkbox"/> | <ul style="list-style-type: none"> Major differences in a.m./p.m. performance | |
| <input type="checkbox"/> | <ul style="list-style-type: none"> Decline in cognition/communication (V0100D) | |
| <input type="checkbox"/> | <ul style="list-style-type: none"> Decline in mood (V0100E, V0100F) | |
| <input type="checkbox"/> | <ul style="list-style-type: none"> Decline in behavior | |
| <input type="checkbox"/> | <ul style="list-style-type: none"> Decline in Activities of Daily Living (ADLs) (G0110) | |

| |
|-------------------------------------------------------------------------------------------------------------------------------------------|
| Input from resident and/or family/representative regarding the care area. (Questions/Comments/Concerns/Preferences/Suggestions) |
| |

| Analysis of Findings | | Care Plan Considerations |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------|-----------------------------------------------------------|
| Review indicators and supporting documentation, and draw conclusions. Document: <ul style="list-style-type: none"> • Description of the problem; • Causes and contributing factors; and • Risk factors related to the care area. | Care Plan Y/N | Document reason(s) care plan will/ will not be developed. |
| | | |

Referral(s) to another discipline(s) is warranted (to whom and why): _____

Information regarding the CAA transferred to the CAA Summary (Section V of the MDS):

☐ Yes ☐ No

Signature/Title: _____ Date: _____

18. PHYSICAL RESTRAINTS**Review of Indicators of Physical Restraints**

| ✓ | Evaluation of current restraint use (based on chart documentation, including care plan) | Supporting Documentation (Basis/reason for checking the item, including the location, date, and source (if applicable) of that information) |
|--------------------------|-----------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------|
| <input type="checkbox"/> | • Does not meet regulatory definition of restraint (stop here and check accuracy of MDS item that triggered this CAA) | |
| <input type="checkbox"/> | • Evidence of informed consent not evident on chart | |
| <input type="checkbox"/> | • Medical symptom not identified for treatment via restraints | |
| <input type="checkbox"/> | • Used for staff convenience | |
| <input type="checkbox"/> | • Used for discipline purposes | |
| <input type="checkbox"/> | • Multiple restraints in use | |
| <input type="checkbox"/> | • Non-restraint interventions not attempted prior to restraining | |
| <input type="checkbox"/> | • Less restrictive devices not attempted | |
| <input type="checkbox"/> | • No regular schedule for removing restraints | |
| <input type="checkbox"/> | • No schedule for frequency by hour of the day for checking on resident's well-being | |
| <input type="checkbox"/> | • No plan for reducing/eliminating restraints | |

| ✓ | Medical conditions/treatments that may lead to restraint use | |
|--------------------------|--------------------------------------------------------------------------------------|--|
| <input type="checkbox"/> | • Indwelling catheter (H0100A), external catheter (H0100B), or ostomy (H0100C) | |
| <input type="checkbox"/> | • Parenteral/IV feeding (K0510A1, K0510A2) | |
| <input type="checkbox"/> | • Feeding tube (K0510B1, K0510B2) | |
| <input type="checkbox"/> | • Pressure ulcer (M0210) or pressure ulcer care (M1200E) | |
| <input type="checkbox"/> | • Other skin ulcers, wounds, skin problems (M1040) or wound care (M1200F-M1200I) | |
| <input type="checkbox"/> | • Oxygen therapy (O0100C) | |
| <input type="checkbox"/> | • Tracheostomy (O0100E, clinical record) | |
| <input type="checkbox"/> | • Ventilator or respirator (O0100F) | |
| <input type="checkbox"/> | • IV medications (O0100H) | |
| <input type="checkbox"/> | • Transfusions (O0100I) | |
| <input type="checkbox"/> | • Functional decline, decreased mobility (clinical record) | |
| <input type="checkbox"/> | • Other medical problem or equipment associated with restraint use (clinical record) | |

| ✓ | Cognitive impairment/behavioral symptoms that may lead to restraint use (also see Cognitive Loss and Behavior CAAs) | Supporting Documentation (Basis/reason for checking the item, including the location, date, and source (if applicable) of that information) |
|--------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------|
| <input type="checkbox"/> | • Inattention, easily distracted (C1300A) | |
| <input type="checkbox"/> | • Disorganized thinking (C1300B) | |
| <input type="checkbox"/> | • Fidgety, restless | |
| <input type="checkbox"/> | • Agitation behavior (E0200) – describe the specific verbal or motor activity- e.g. screaming, babbling, cursing, repetitive questions, pacing, kicking, scratching, etc. | |
| <input type="checkbox"/> | • Confusion (C0100, C0600) | |
| <input type="checkbox"/> | • Psychosis (E0100A, E0100B) | |
| <input type="checkbox"/> | • Physical symptoms directed toward others (E0200A) | |
| <input type="checkbox"/> | • Verbal behavioral symptoms directed toward others (E0200B) | |
| <input type="checkbox"/> | • Rejection of care (E0800) | |
| <input type="checkbox"/> | • Wandering (E0900) | |
| <input type="checkbox"/> | • Delirium (C1600), including side effects of medications (clinical record) | |
| <input type="checkbox"/> | • Alzheimer's disease (I4200) or other dementia (I4800) | |
| <input type="checkbox"/> | • Traumatic brain injury (I5500) | |
| <input type="checkbox"/> | • Psychiatric disorder (I5700-I6100) | |

| ✓ | Risk for falls that may lead to restraint use (also see Falls CAA) | |
|--------------------------|------------------------------------------------------------------------------------------------------------------------------|--|
| <input type="checkbox"/> | • Poor safety awareness, impulsivity (clinical record) | |
| <input type="checkbox"/> | • Urinary urgency (clinical record) | |
| <input type="checkbox"/> | • Incontinence of bowel and/or bladder (H0300, H0400) | |
| <input type="checkbox"/> | • Side effect of medication, such as dizziness, postural/orthostatic hypotension (I0800), sedation, etc. (clinical record) | |
| <input type="checkbox"/> | • Insomnia, fatigue (D0200D, D0500D) | |
| <input type="checkbox"/> | • Need for assistance with mobility (G0110) | |
| <input type="checkbox"/> | • Balance problem (G0300) | |
| <input type="checkbox"/> | • Postural/orthostatic hypotension (I0800, clinical record) | |
| <input type="checkbox"/> | • Hip or other fracture (I3900, I4000) | |
| <input type="checkbox"/> | • Hemiplegia/hemiparesis (I4900), paraplegia (I5000), quadriplegia (I5100) | |
| <input type="checkbox"/> | • Other neurological disorder (for example, Cerebral Palsy (I4400), Multiple Sclerosis (I5200), Parkinson's Disease (I5300)) | |
| <input type="checkbox"/> | • Respiratory problems (J1100, I6200, I6300, clinical record) | |
| | • History of falls (J1700 – J1900) | |

| ✓ | Adverse reaction to restraint use | Supporting Documentation (Basis/reason for checking the item, including the location, date, and source (if applicable) of that information) |
|--------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <input type="checkbox"/> | • Skin breakdown (Section M) | |
| <input type="checkbox"/> | • Incontinence or increased incontinence (H0300, H0400, clinical record) | |
| <input type="checkbox"/> | • Moisture associated skin damage (M1040H) | |
| <input type="checkbox"/> | • Constipation (H0600) | |
| <input type="checkbox"/> | • Increased agitation behavior (E0200, clinical record) – describe the specific verbal or motor activity- e.g. screaming, babbling, cursing, repetitive questions, pacing, kicking, scratching, etc. | |
| <input type="checkbox"/> | • Depression, withdrawal, diminished dignity, social isolation (I5800, I5900, clinical record) | |
| <input type="checkbox"/> | • Loss of muscle mass, contractures, lessened mobility (G0110, G0300, G0400) and stamina (clinical record) | |
| <input type="checkbox"/> | • Infections, such as UTI or pneumonia (I1700 – I2500) | |
| <input type="checkbox"/> | • Frequent attempts to get out of the restraints (P0100), falls (J1700 – J1900, clinical record) | |

| |
|-------------------------------------------------------------------------------------------------------------------------------------------|
| Input from resident and/or family/representative regarding the care area. (Questions/Comments/Concerns/Preferences/Suggestions) |
| |

| Analysis of Findings | | Care Plan Considerations |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------|-----------------------------------------------------------|
| Review indicators and supporting documentation, and draw conclusions. Document: <ul style="list-style-type: none"> • Description of the problem; • Causes and contributing factors; and • Risk factors related to the care area. | Care Plan Y/N | Document reason(s) care plan will/ will not be developed. |
| | | |

Referral(s) to another discipline(s) is warranted (to whom and why): _____

Information regarding the CAA transferred to the CAA Summary (Section V of the MDS):

☐ Yes ☐ No

Signature/Title: _____ Date: _____

19. PAIN**Review of Indicators of Pain**

| ✓ | Diseases and conditions that may cause pain (diagnosis OR signs/symptoms present) | Supporting Documentation (Basis/reason for checking the item, including the location, date, and source (if applicable) of that information) |
|--------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <input type="checkbox"/> | <ul style="list-style-type: none"> • Cancer (I0100) | |
| <input type="checkbox"/> | <ul style="list-style-type: none"> • Circulatory/heart <ul style="list-style-type: none"> — Angina, Myocardial Infarction (MI), Atherosclerotic Heart Disease (ASHD) (I0400) — Deep Vein Thrombosis (I0500) — Peripheral Vascular Disease (I0900) | |
| <input type="checkbox"/> | <ul style="list-style-type: none"> • Skin/Wound <ul style="list-style-type: none"> — Pressure ulcer (section M) — Other ulcers, wounds, incision, skin problems (M1040) — Moisture associated skin damage (M1040H) | |
| <input type="checkbox"/> | <ul style="list-style-type: none"> • Infections <ul style="list-style-type: none"> — Urinary tract infection (I2300) — Pneumonia (I2000) | |
| <input type="checkbox"/> | <ul style="list-style-type: none"> • Neurological (I4200 – I5500) <ul style="list-style-type: none"> — Head trauma (clinical record) — Headache — Neuropathy — Post-stroke syndrome | |
| <input type="checkbox"/> | <ul style="list-style-type: none"> • Gastrointestinal <ul style="list-style-type: none"> — Gastroesophageal Reflux Disease/Ulcer (I1200) — Ulcerative Colitis/Crohn's Disease/Inflammatory Bowel Disease (I1300) — Constipation (H0600, clinical record, resident interview) | |
| <input type="checkbox"/> | <ul style="list-style-type: none"> • Hospice care (O0100K) | |
| <input type="checkbox"/> | <ul style="list-style-type: none"> • Musculoskeletal <ul style="list-style-type: none"> — Arthritis (I3700) — Osteoporosis (I3800) — Hip fracture (I3900) — Other fracture (I4000) — Back problems (I8000) — Amputation (O0500) — Other (I8000) | |
| <input type="checkbox"/> | <ul style="list-style-type: none"> • Dental problems (section L) (L0200) | |

| | | |
|--------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------|
| | | Supporting Documentation (Basis/reason for checking the item, including the location, date, and source (if applicable) of that information) |
| ✓ | Characteristics of the pain | |
| <input type="checkbox"/> | • Location | |
| <input type="checkbox"/> | • Type (constant, intermittent, varies over time, etc.) | |
| <input type="checkbox"/> | • What makes it better | |
| <input type="checkbox"/> | • What makes it worse | |
| <input type="checkbox"/> | • Words that describe it (for example, aching, soreness, dull, throbbing, crushing) — Burning, pins and needles, shooting, numbness (neuropathic) — Cramping, crushing, throbbing, stabbing (musculoskeletal) — Cramping, tightness (visceral) | |

| | | |
|--------------------------|------------------------------------------------------------------|--|
| ✓ | Frequency and intensity of the pain (J0400, J0600, J0850) | |
| <input type="checkbox"/> | • How often it occurs | |
| <input type="checkbox"/> | • Time or situation of onset | |
| <input type="checkbox"/> | • How long it lasts | |

| | | |
|--------------------------|----------------------------------------------------------------------------------------|--|
| ✓ | Non-verbal indicators of pain (particularly important if resident is stoic) | |
| <input type="checkbox"/> | • Facial expression (frowning, grimacing, etc.) (J0800A, J0800C) | |
| <input type="checkbox"/> | • Vocal behaviors (signing, moaning, groaning, crying, etc.) (J0800A, J0800B) | |
| <input type="checkbox"/> | • Body position (guarding, distorted posture, restricted limb movement, etc.) (J0800D) | |
| <input type="checkbox"/> | • Restlessness | |

| | | |
|--------------------------|--------------------------------------------------------------------------------------|--|
| ✓ | Pain effect on function | |
| <input type="checkbox"/> | • Disturbs sleep (J0500A) | |
| <input type="checkbox"/> | • Decreases appetite (clinical record) | |
| <input type="checkbox"/> | • Adversely affects mood (D0200, D0500, clinical record) | |
| <input type="checkbox"/> | • Limits day-to-day activities (J0500B) (social events, eating in dining room, etc.) | |
| <input type="checkbox"/> | • Limits independence with at least some Activities of Daily Living (ADLs) (G0110) | |

| ✓ | Associated signs and symptoms | Supporting Documentation (Basis/reason for checking the item, including the location, date, and source (if applicable) of that information) |
|--------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------|
| <input type="checkbox"/> | <ul style="list-style-type: none"> Agitation or new or increased behavior problems (E0200) – describe the specific verbal or motor activity- e.g. screaming, babbling, cursing, repetitive questions, pacing, kicking, scratching, etc. | |
| <input type="checkbox"/> | <ul style="list-style-type: none"> Delirium (C1600) | |
| <input type="checkbox"/> | <ul style="list-style-type: none"> Withdrawal | |

| ✓ | Other Considerations | |
|--------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------|--|
| <input type="checkbox"/> | <ul style="list-style-type: none"> Improper positioning (M1200C) | |
| <input type="checkbox"/> | <ul style="list-style-type: none"> Contractures (G0400) | |
| <input type="checkbox"/> | <ul style="list-style-type: none"> Immobility (G0110) | |
| <input type="checkbox"/> | <ul style="list-style-type: none"> Use of restraints (P0100) | |
| <input type="checkbox"/> | <ul style="list-style-type: none"> Recent change in pain (characteristics, frequency, intensity, etc.) (J0400, J0600) | |
| <input type="checkbox"/> | <ul style="list-style-type: none"> Insufficient pain relief (from resident/staff interview, clinical record, direct observation) (J0100 – J0850) | |
| <input type="checkbox"/> | <ul style="list-style-type: none"> Pain relief occurs, but duration is not sufficient, resulting in breakthrough pain (J0100 – J0850) | |

| |
|-------------------------------------------------------------------------------------------------------------------------------------------|
| Input from resident and/or family/representative regarding the care area. (Questions/Comments/Concerns/Preferences/Suggestions) |
| |

| Analysis of Findings | | Care Plan Considerations |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------|-----------------------------------------------------------|
| Review indicators and supporting documentation, and draw conclusions. Document: <ul style="list-style-type: none"> • Description of the problem; • Causes and contributing factors; and • Risk factors related to the care area. | Care Plan Y/N | Document reason(s) care plan will/ will not be developed. |
| | | |

Referral(s) to another discipline(s) is warranted (to whom and why): _____

Information regarding the CAA transferred to the CAA Summary (Section V of the MDS):

☐ Yes ☐ No

Signature/Title: _____ Date: _____

20. RETURN TO COMMUNITY REFERRAL**Review of Return to Community Referral**

| ✓ | Steps in the Process |
|--------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <input type="checkbox"/> | 1. Document in the care plan whether the individual indicated a desire to talk to someone about the possibility of returning to the community or not (Q0500B). |
| <input type="checkbox"/> | 2. Discuss with the individual and his or her family to identify potential barriers to transition planning. The care planning/discharge planning team should have additional discussions with the individual and family to develop information that will support the individual's smooth transition to community living. (Q0100) |
| <input type="checkbox"/> | 3. Other factors to consider regarding the individual's discharge assessment and planning for community supports include: <ul style="list-style-type: none"> • Cognitive skills for decision making (C1000) and Cognitive deficits (C0500, C0700-C1000) • Functional/mobility (G0110) or balance (G0300) problems • Need for assistive devices and/or home modifications if considering a discharge home |
| <input type="checkbox"/> | 4. Inform the discharge planning team and other facility staff of the individual's choice. |
| <input type="checkbox"/> | 5. Look at the previous care plans of this individual to identify their previous responses and the issues or barriers they expressed. Consider the individual's overall goals of care and discharge planning from previous items responses (Q0300 and Q0400B). Has the individual indicated that his or her goal is for end-of-life-care (palliative or hospice care)? Or does the individual expect to return home after rehabilitation in your facility? (Q0300, Q0400) |
| <input type="checkbox"/> | 6. Initiate contact with the State-designated local contact agency within approximately 10 business days, and document (Q0600). Follow-up is expected in a "reasonable" amount of time, 10 business days is a recommendation and not a requirement. |
| <input type="checkbox"/> | 7. If the local contact agency does not contact the individual by telephone or in person within approximately 10 business days, make another follow-up call to the designated local contact agency as necessary. The level and type of response needed by a particular individual is determined on a resident-by-resident basis, so timeframes for response may vary depending on the needs of the resident and the supports available within the community. |
| <input type="checkbox"/> | 8. Communicate and collaborate with the State-designated local contact agency on the discharge process. Identify and address challenges and barriers facing the individual in their discharge process. Develop solutions to these challenges in the discharge/transition plan. |
| <input type="checkbox"/> | 9. Communicate findings and concerns with the facility discharge planning team, the individual's support circle, the individual's physician and the local contact agency in order to facilitate discharge/transition planning. |

| |
|-------------------------------------------------------------------------------------------------------------------------------------------|
| Input from resident and/or family/representative regarding the care area. (Questions/Comments/Concerns/Preferences/Suggestions) |
| |

| Analysis of Findings | | Care Plan Considerations |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------|-----------------------------------------------------------|
| Review indicators and supporting documentation, and draw conclusions. Document: <ul style="list-style-type: none"> • Description of the problem; • Causes and contributing factors; and • Risk factors related to the care area. | Care Plan Y/N | Document reason(s) care plan will/ will not be developed. |
| | | |

Referral(s) to another discipline(s) is warranted (to whom and why): _____

Information regarding the CAA transferred to the CAA Summary (Section V of the MDS):

☐ Yes ☐ No

Signature/Title: _____ Date: _____

CARE AREA GENERAL RESOURCES

The general resources contained on this page are not specific to any particular care area. Instead, they provide a general listing of known clinical practice guidelines and tools that may be used in completing the RAI CAA process.

NOTE: This list of resources is neither prescriptive nor all-inclusive. References to non-U.S. Department of Health and Human Services (HHS) sources or sites on the Internet are provided as a service and do not constitute or imply endorsement of these organizations or their programs by CMS or HHS. CMS is not responsible for the content of pages found at these sites. URL addresses were current as of the date of this publication.

- Advancing Excellence in America's Nursing Homes Resources:
http://www.nhqualitycampaign.org/star_index.aspx?controls=resImplementationGuides;
- Agency for Health Care Research and Quality – Clinical Information, Evidence-Based Practice: <http://www.ahrq.gov/clinic/>;
- Alzheimer's Association Resources:
http://www.alz.org/professionals_and_researchers_14899.asp#professional;
- American Dietetic Association – Individualized Nutrition Approaches for Older Adults in Health Care Communities (PDF Version):
<http://www.eatright.org/About/Content.aspx?id=8373>;
- American Geriatrics Society Clinical Practice Guidelines and Tools:
http://www.americangeriatrics.org/health_care_professionals/clinical_practice/featured_programs_products/;
- American Medical Directors Association (AMDA) Clinical Practice Guidelines and Tools: <http://www.amda.com/tools>;
- American Pain Society: http://www.ampainsoc.org/pub/cp_guidelines.htm;
- American Society of Consultant Pharmacists Practice Resources:
<http://www.ascp.com/articles/professional-development/clinical-practice-resources>;
- Association for Professionals in Infection Control and Epidemiology Practice Resources:
<http://www.apic.org/AM/Template.cfm?Section=Practice>;
- Centers for Disease Control and Prevention: Infection Control in Long-Term Care Facilities Guidelines: http://www.cdc.gov/HAI/settings/ltc_settings.html;
- CMS Pub. 100-07 State Operations Manual Appendix PP – Guidance to Surveyors for Long Term Care Facilities (federal regulations noted throughout; resources provided in endnotes): http://cms.gov/manuals/Downloads/som107ap_pp_guidelines_ltc.pdf;
- Emerging Solutions in Pain Tools: <http://www.emergingsolutionsinpain.com/>;
- Hartford Institute for Geriatric Nursing Access to Important Geriatric Tools:
<http://www.hartfordign.org/resources>;
- Hartford Institute for Geriatric Nursing Evidence-Based Geriatric Content:
<http://www.hartfordign.org/practice/consultgerirn/>;
- Improving Nursing Home Culture (CMS Special Study):
<http://www.healthcentricadvisors.org/images/stories/documents/inhc.pdf>
- Institute for Safe Medication Practices: <http://www.ismp.org/>;
- Quality Improvement Organizations:
<http://www.qualitynet.org/dcs/ContentServer?c=Page&pagename=QnetPublic%2FPage%2FQnetTier2&cid=1144767874793>;

CARE AREA GENERAL RESOURCES (cont.)

- University of Missouri's Geriatric Examination Tool Kit: <http://web.missouri.edu/~proste/tool/>; and
- U.S. Department of Health and Human Services Agency for Healthcare Research and Quality's National Guideline Clearinghouse: <http://www.guideline.gov/>;